

Michigan Coordinated HIV/AIDS Needs Assessment 2015



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NEEDS ASSESSMENT REPORT CONTENT

In June of 2015, the Health Resources and Services Administration and the Centers for Disease Control released their Integrated HIV Prevention and Care Plan Guidance, including the Statewide Coordinated Statement of Need. In preparation for the release of this new guidance, the Michigan Department of Health and Human Services contracted with an outside organization, Michigan Public Health Institute in fall of 2014 to lead the development of a statewide coordinated needs assessment that included significant input from the two major health departments (Michigan Department of Health and Human Services and the Detroit Department of Health and Wellness Promotion) and two major HIV/AIDS planning bodies (Michigan HIV/AIDS Council and the Southeastern Michigan HIV/AIDS planning Council).

The needs assessment process had several broad requirements which were to convene and facilitate a multidisciplinary group of stakeholders (including providers, clients and community members and health department staff), referred to as the Steering Committee to provide guidance throughout the needs assessment process; and conduct a thorough assessment of the HIV prevention and care related needs of three major populations of individuals in Michigan: persons living with HIV/AIDS, persons at-risk for HIV/AIDS, and the health care and service professionals who comprise the HIV care and prevention system. Much of the existing care and prevention data within Michigan were collected up to five years ago so the gathering of updated data from populations of interest was a priority for the Steering Committee. Much of the data contained herein reflect original surveys conducted during the summer of 2015.

This needs assessment narrative describes the collaborative efforts of the Michigan Department of Health and Human Services, Michigan HIV/AIDS Council, Detroit Department of Health and Wellness and the Southeastern HIV/AIDS Council, together referred to as the Steering Committee and the outside consultant organization. Results from the needs assessment will be used to develop a coordinated statewide plan to address care and prevention activities in Michigan for the next five years.

The needs assessment process involved working with a large group of stakeholders representing several different jurisdictions and areas of interest in Michigan. As with any diverse group of stakeholders, each individual group was not able to capture all of the information that they desired during the needs assessment process. However, needs assessments should be an ongoing process and future assessments can target any additional data that were not collected during this process.

The needs assessment process utilized the Mobilizing for Action through Planning and Partnerships (MAPP) model. This evidence based model is a comprehensive, data-informed approach to assessment that embodies the principle of collaboration with a community-driven approach. The MAPP process utilizes four assessments to compile existing data and collect and analyze new data.

This report is organized around the results of the four MAPP assessments:

1. Health Status Assessment: The Health Status Assessment compiled existing (secondary) data to provide an understanding of the demographic characteristics of the populations affected by HIV/AIDS, and the incidence, prevalence and trends in HIV infection in Michigan incidence,

prevalence and trends in HIV infection in Michigan. Gaps in existing data were used to prioritize primary data collection in the other three assessments.

2. Health System Assessment: As part of the Health System Assessment primary data were collected to examine characteristics and gaps in the health care and service delivery system.
3. Themes and Strengths Assessment: As part of the Themes and Strengths Assessment, primary data were collected from persons living with HIV/AIDS and at risk for HIV/AIDS to provide an understanding of issues and concerns related to quality of life, testing, care, and service needs.
4. Forces of Change: The Forces of Change Assessment involved a brainstorming session aimed at identifying social, political and economic forces that influence the health and quality of life of individuals living with or at risk for HIV/AIDS.

The report is organized into 11 sections. Each section starts with a summary of the data contained within and a description of the relevant MAPP assessment.

- Section 1 provides a description of the needs assessment process
- Section 2 provides a description of the demographic characteristics in the state of Michigan using previously existing (secondary) data
- Section 3 provides a description of individuals living with at risk for HIV in Michigan using a combination of previously existing (secondary) data and newly collected (primary) data
- Section 4 provides a description of the provider system in Michigan using newly collected (primary) data on health care, service organization and jail providers
- Section 5 provides a description of the demographic characteristics in the Detroit Metropolitan Area (DMA) using previously existing (secondary) data. The DMA which consists of Wayne, Oakland, Lapeer, St. Clair, Monroe, and Macomb counties.
- Section 6 provides a description of individuals living with at risk for HIV in the DMA using a combination of previously existing (secondary) data and newly collected (primary) data
- Section 7 provides a description of the provider system in the DMA using newly collected (primary) data on health care, service organization and jail providers
- Section 8 describes the socio political factors that impact the HIV prevention and care systems along with persons living with HIV/AIDS in both Michigan and the DMA
- Section 9 outlines preliminary needs assessment recommendations
- Section 10 describes the prevention and care resource inventory process and outcome for both Michigan and the DMA
- Section 11 describes the sources for all data mentioned in the needs assessment report and the limitations of the needs assessment process.

SECTION 1: INTRODUCTION

1.1 NEEDS ASSESSMENT PROCESS

In June of 2015, the Health Resources and Services Administration and the Centers for Disease Control released their Integrated HIV Prevention and Care Plan Guidance, including the Statewide Coordinated Statement of Need. In preparation for the release of this new guidance, the Michigan Department of Health and Human Services (MDHHS) contracted with an outside organization, Michigan Public Health Institute (MPHI) in fall of 2014 to lead the development of a statewide coordinated needs assessment that included significant input from the two major health departments, Michigan Department of Health and Human Services (MDHHS) and the Detroit Department of Health and Wellness Promotion (DHWP) and two major HIV/AIDS planning bodies, the Michigan HIV/AIDS Council (MHAC) and the Southeastern Michigan HIV/AIDS planning Council (SEMHAC).

The needs assessment process had several broad requirements which were to convene and facilitate a multidisciplinary group of stakeholders (including providers, clients and community members and health department staff), referred to as the Steering Committee to provide guidance throughout the needs assessment process; and conduct a thorough assessment of the HIV prevention and care related needs of three major populations of individuals in Michigan: persons living with HIV/AIDS, persons at-risk for HIV/AIDS, and the health care and service professionals who comprise the HIV care and prevention system. Much of the existing care and prevention data within Michigan were collected up to five years ago so the gathering of updated data from populations of interest was a priority for the Steering Committee. The remainder of this section describes the process used to facilitate the statewide coordinated needs assessment process.

1.2 MOBILIZING FOR ACTION THROUGH PLANNING AND PARTNERSHIPS

The Michigan coordinated needs assessment followed an evidence-based process called the Mobilizing for Action through Planning and Partnerships (MAPP) model. The model was developed by the Centers for Disease Control and Prevention (CDC) and the National Association of County and City Health Officials (NACCHO), as a comprehensive, data-informed approach to assessment that embodies the principle of collaboration with a community-driven approach.

Representatives from the Michigan Public Health Institute (MPHI) led the needs assessment process and served as the “Core Support Team”. Other key stakeholder groups involved in the needs assessment process included the steering committee, subcommittees and the HIV community. The following chart and figure includes a description of the roles and responsibilities of all individuals involved in the needs assessment process.

Figure 1: MAPP Model



Table 1. Roles and responsibilities of needs assessment committee members.

Michigan Public Health Institute/ Core Support Team	Steering Committee	Subcommittees	HIV Community
<ul style="list-style-type: none"> Organize and plan the process Identify resources Conduct readiness assessment Oversee data collection Compile and present results 	<ul style="list-style-type: none"> Guide and oversee the MAPP process Provide input on participant recruitment Approve plan for Assessment process (as determined by Core Support Team) Identify additional resources Make community aware of needs assessment activities 	<ul style="list-style-type: none"> Consists of community and steering committee members Participates in one or more assessments Serves in an advisory role Provides feedback on assessments and interpretation of results 	<ul style="list-style-type: none"> Provide both formal and informal input through assessments

The MPHI MAPP approach utilized the following steps:

1. **Organize for Success/Partnership Development.** State-wide planning requires strong organization and a high level of commitment from stakeholders in the HIV community (e.g., providers, local public health, community-based organizations, faith-based organizations, persons living with HIV, persons at-risk for HIV, etc.). The first phase of MAPP involved two critical and interrelated activities: organizing the planning process and developing the planning partnership. The purpose of this phase was to structure a planning process that ensured commitment, engaged participants as active partners, used participants' time well, and resulted in a plan that can be realistically implemented. The steering committee, which was instrumental in guiding and overseeing the MAPP process was recruited and selected during this phase. Members of the steering committee represented state and local government, community based organizations, providers, educators, consumers, and HIV planning bodies. A list of participating organizations is included in the appendix.
2. **Visioning.** Developing a shared vision and common values provides a framework for pursuing long-range state-wide goals. Visioning took place during 4 in person meetings with the steering committee at the beginning of the process and was used as a mechanism to convene the community, build enthusiasm for the process, set the stage for planning and providing a common framework throughout the process. Visioning took place on the following dates:
 - October 16 – Detroit, Michigan
 - November 17 – Detroit, Michigan
 - December 3 – Brighton, Michigan

- January 15 – Lansing, Michigan

3. **The Four MAPP Assessments.** The MAPP process utilizes four assessments to compile existing data and collect and analyze new data. Detail on the four MAPP assessments is included below.
 - a. **Health Status Assessment:** The Health Status Assessment compiled existing (secondary) data to provide an understanding of the demographic characteristics populations affected by HIV/AIDS, and the incidence, prevalence and trends in HIV infection in Michigan. Additional detail on the data collected through this assessment is discussed in Sections 2: Description of Michigan; Section 3.1: Epidemiological Overview of HIV/AIDS in Michigan; Section 5: Description of the Detroit Metropolitan Area; and Section 6.1: Epidemiological Overview of HIV/AIDS in the Detroit Metropolitan Area. Gaps in existing data were used to prioritize primary data collection in the other three assessments.
 - b. **Health System Assessment:** As part of the Health System Assessment primary data were collected to examine characteristics and gaps in the health care and service delivery system. Additional detail on the health system assessment is discussed in Section 4: Survey of Professionals Providing Care and Services to individuals Living with HIV/AIDS in Michigan; and Section 7: Survey of Professionals Providing Care and Services to individuals Living with HIV/AIDS in the Detroit Metropolitan Area.
 - c. **Themes and Strengths Assessment:** As part of the Themes and Strengths Assessment, primary data were collected from persons living with HIV/AIDS and at risk for HIV/AIDS to provide an understanding of issues and concerns related to quality of life, testing, care, and service needs. Additional detail on the Themes and Strengths assessment is discussed in Section 3.2: Survey among Persons Living with HIV/AIDS in Michigan; Section 3.3: Survey of Persons At-Risk for HIV/AIDS in Michigan; Section 3.4: Community Engagement Surveys in Michigan; Section 6.2: Survey among Persons Living with HIV/AIDS in the Detroit Metropolitan Area; Section 6.3: Survey of Persons At-Risk for HIV/AIDS in the Detroit Metropolitan Area.
 - d. **Forces of Change:** The Forces of Change Assessment involved a brainstorming session aimed at identifying social, political and economic forces that influence the health and quality of life of individuals living with or at risk for HIV/AIDS. Additional information on the forces of change assessment can be found in Section 8. Socio-Political Factors Impacting the HIV/AIDS Epidemic in Michigan.

Each of the assessments had an associated subcommittee made up of members from the larger steering committee. Each of the subcommittee members served in an advisory role and provided feedback on the direction of assessment data collection and interpretation of assessment data. The below figure depicts the flow of information from the Core Support Team throughout the steering committee and subcommittees. The Steering Committee and Subcommittees met in person 16 times from November 2014 to August 2015. Between meetings information was shared primarily via email.

Information Flow

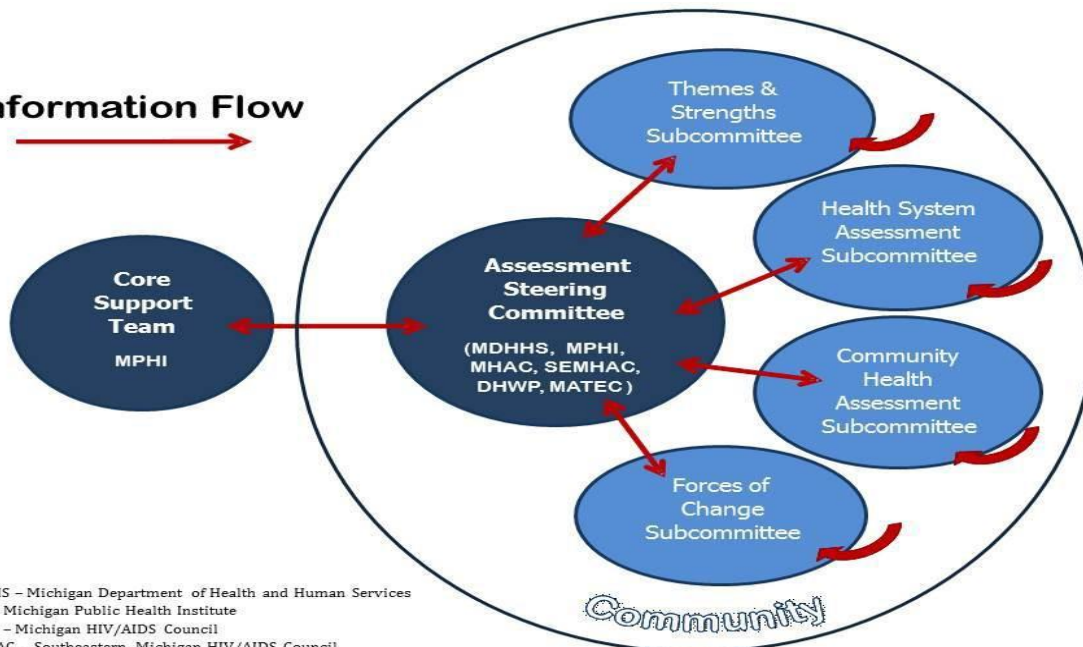


Figure 2: Information flow during the needs assessment process

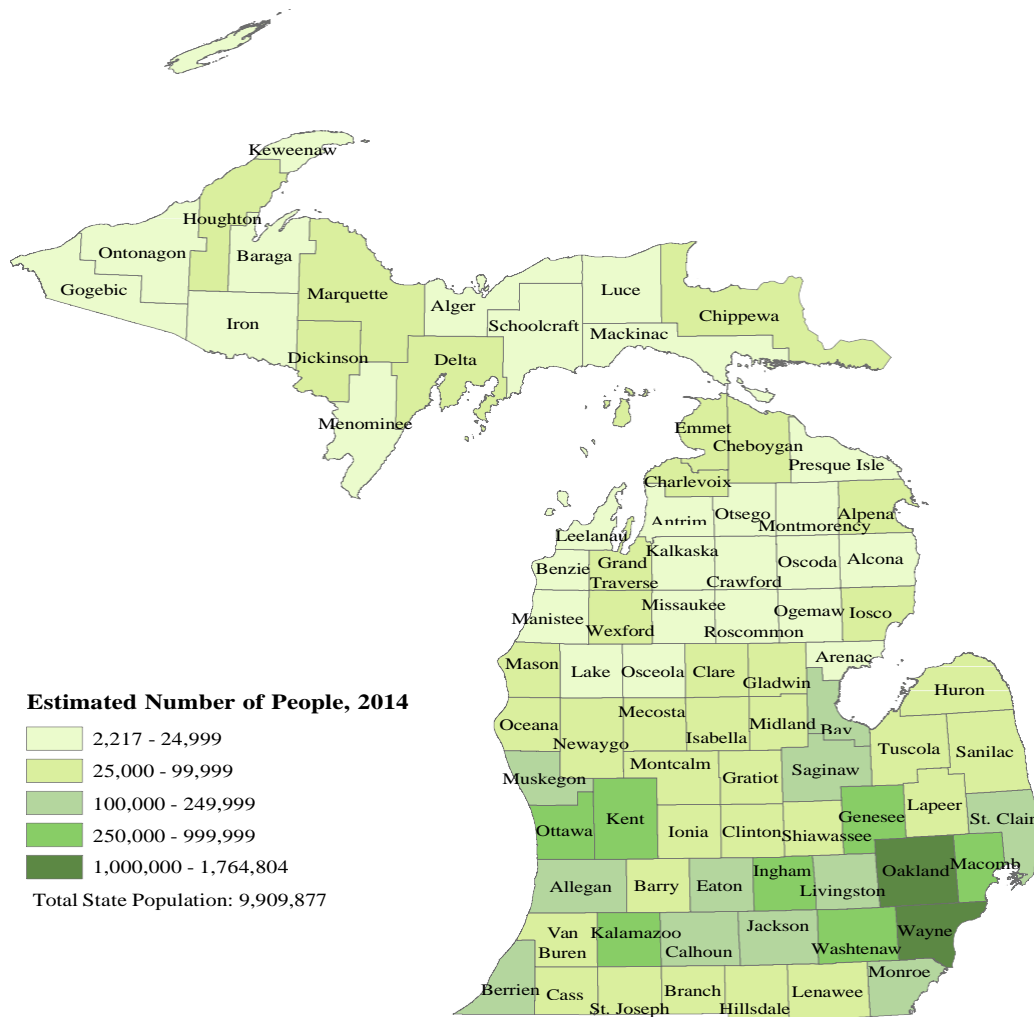
SECTION 2: DESCRIPTION OF MICHIGAN

The Health Status Assessment compiled existing (secondary) data to provide an understanding of the demographic characteristics populations affected by HIV/AIDS, and the incidence, prevalence and trends in HIV infection in Michigan. This section describes the population demographics of Michigan residents using secondary data sources.

2.1 OVERALL POPULATION

According to 2014 U.S. Census estimates, Michigan is the 9th most populous state with an estimated population of 9.9 million, people who represent approximately 3% of the United States population. Michigan consists of eighty-three counties, with the greatest proportion of Michigan residents residing in Wayne County (18%), followed by Oakland County (12%), Macomb County (9%), Kent County (6%), and Genesee County (4%) (Figure 3).

Figure 3: Total population by county, Michigan



Source: U.S. Census Bureau, Annual Estimates of the Resident Population, 2014.

2.2 RACE AND ETHNICITY

Table 2 displays the racial/ethnic distribution of Michigan residents for 2013. The U.S. Census estimates that approximately 77% of Michigan's population are white, non-Hispanic, 14% are Black/African American, non-Hispanic, 2% are Asian/Pacific Islander, and less than 1% are American Indian/Alaska Native. Approximately 4% of Michigan's population is of Hispanic ethnicity.

Table 2. Michigan population by race/ethnicity, 2013

Race/Ethnicity	N	%
White, non-Hispanic	7,569,939	76.6%
Black/African American, non-Hispanic	1,383,756	14.0%
Hispanic	436,358	4.4%
Asian/Pacific Islander	238,660	2.4%
American Indian/Alaska Native	54,665	0.6%
Some Other Race	9,866	0.1%
Source: U.S. Census, Annual Estimates of the Resident Population, 2013		

2.3 AGE AND SEX

Approximately 49% of Michigan's residents are male and 51% are female. The age distribution for males and females in Michigan is similar, except among older residents. A greater proportion of females (17%) are 65 years and older compared to males (13%). Approximately 33% of the population in Michigan is less than 25 years of age (Table 3).

Table 3. Michigan population by age and gender, 2013

	Total		Male		Female	
	N	%	N	%	N	%
< 14 years	1,835,906	19%	941,334	19%	894,572	18%
15 - 19	691,280	7%	352,730	7%	338,550	7%
20 - 24	723,141	7%	367,100	8%	356,041	7%
25 - 29	592,095	6%	298,319	6%	293,776	6%
30 - 34	588,428	6%	291,701	6%	296,727	6%
35 - 39	556,475	6%	277,414	6%	279,061	6%
40 - 44	652,628	7%	321,808	7%	330,820	7%
45 - 49	676,506	7%	335,906	7%	340,600	7%
50 - 54	743,377	8%	364,935	8%	378,442	8%
55 to 59	730,583	7%	356,341	7%	374,242	7%
60 to 64	618,420	6%	295,965	6%	322,455	6%
65 and over	1,486,783	15%	654,585	13%	832,198	17%
Total	9,895,622		4,858,138		5,037,484	
Source: U.S. Census, American Community Survey, 2013						

2.4 EDUCATIONAL ATTAINMENT

Table 4 presents educational attainment for Michigan residents aged 25 years and older. Twenty-six percent of adults 25 years and older received a Bachelor's degree or higher and nearly 90% received a high school diploma or general diploma (GED equivalency). The same percent of males (26%) and females (26%) have received a Bachelor's degree or higher and slightly more females (90%) than males (88%) are high school graduates or higher. Older residents (age 65 years and over) had the lowest level of educational attainment compared to younger age groups.

Table 4: Educational attainment for ages 25 years and older, Michigan, 2013

	Education Level	
	High School Graduate or Higher %	Bachelor's Degree or Higher %
Total	89	26
Gender		
Male	88	26
Female	90	26
Age (years)		
25-34	90	30
35-44	91	31
45-64	91	26
65+	82	20
Source: U.S. Census, American Community Survey, 2013		

Figure 4 presents poverty estimates for all counties in Michigan. In 2013, the estimated proportion of people living in poverty for all ages in Michigan was 17%. These estimates ranged from 6% to 31% across counties. Lake County (31%), Isabella County (29%), and Wayne County (25%) had the highest proportion of population living in poverty while Livingston County (6%), Clinton County (10%), Leelanau County (10%) and Oakland County (10%) had the lowest proportion of population living in poverty.

Percent Population in Poverty, 2013

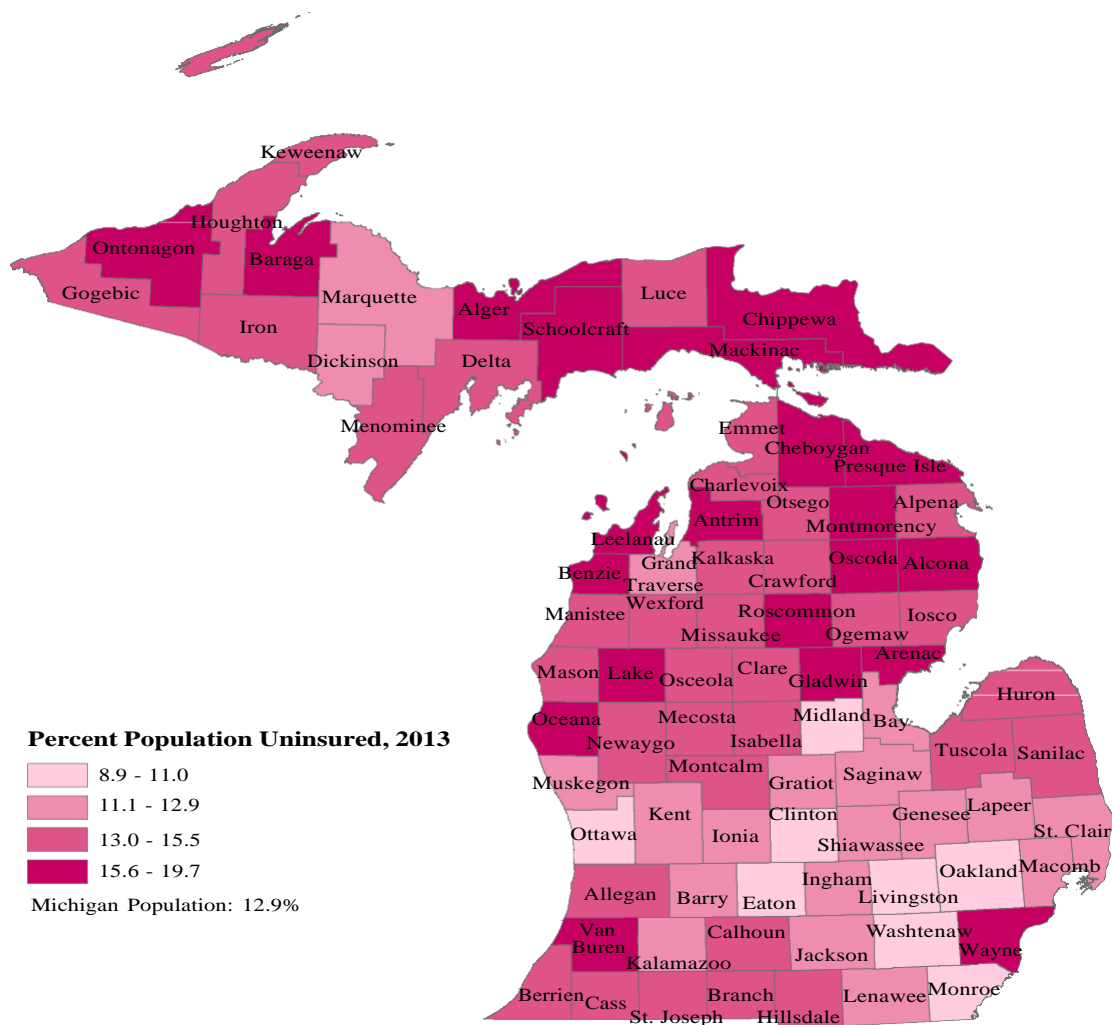
- 6.4 - 13.9
- 14.0 - 17.0
- 17.1 - 20.9
- 21.0 - 31.0

Michigan Population: 17.0%

17

Figure 5 presents the proportion of population in Michigan who are uninsured. In 2013, the estimated proportion of people uninsured in Michigan was 13%. These estimates ranged from 9% to 20% across counties. Mackinac County (20%), Alcona County (19%), and Oscoda County (25%) had the highest proportion of uninsured residents while Livingston County (9%), Clinton County (10%), and Eaton County (10%) had the lowest proportion of uninsured residents.

Figure 5: Percent population uninsured by county, Michigan, 2013



Source: U.S. Census Bureau, Small Area Health Insurance Estimates, 2013.

SECTION 2 SUMMARY: MICHIGAN'S POPULATION

- Michigan is comprised of 83 counties with a population of 9.9 million, representing approximately 3% of the U.S. population. The five most populous counties in Michigan are Wayne, Oakland, Macomb, Kent, and Genesee.
- Approximately 77% of Michigan's population is White, non-Hispanic, 14% are Black, non-Hispanic, 2% are Asian/Pacific Islander, and 4% are of Hispanic ethnicity. American Indian/Alaska Natives account for less than one percent of Michigan's population.
- Approximately 49% of Michigan's residents are male and 51% are female. The age distribution for males and females in Michigan is similar, except among older residents. A greater proportion of females are 65 years and older compared to males. One-third of the population in Michigan is less than 25 years of age.
- The majority of Michigan's population has received a high school diploma or GED equivalent with 26% of Michigan adults having received a Bachelor's degree or higher.
- Nearly 20% of Michigan's residents live in poverty. The counties of Lake, Isabella, and Wayne had the highest proportion of population living in poverty.
- The estimated proportion of people uninsured in Michigan is 13%. The counties of Mackinac, Alcona, and Oscoda had the highest proportion of uninsured residents.

SECTION 3: HIV/AIDS IN MICHIGAN

3.1 EPIDEMIOLOGIC OVERVIEW

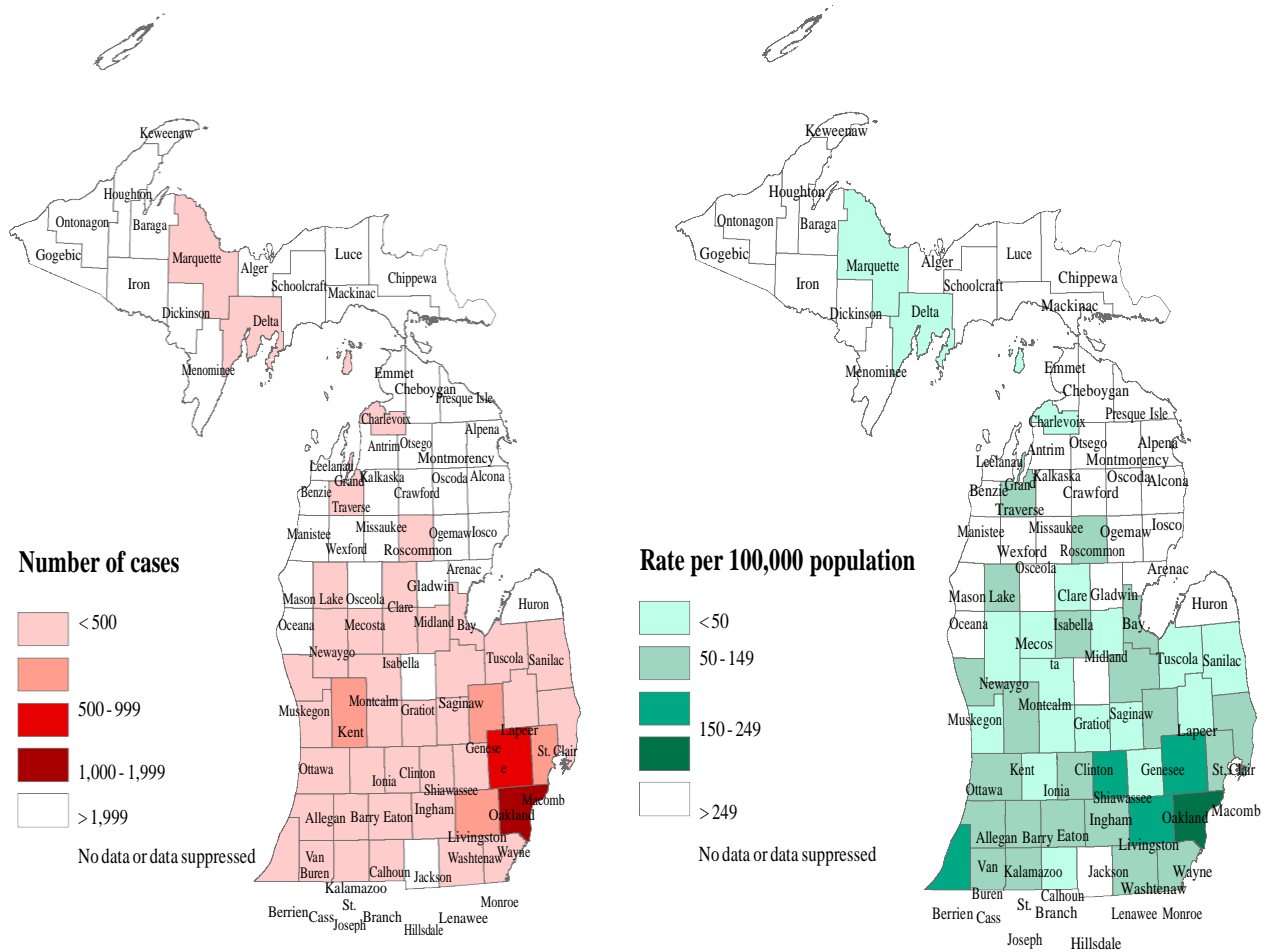
The Health Status Assessment compiled existing (secondary) data to provide an understanding of the demographic characteristics populations affected by HIV/AIDS, and the incidence, prevalence and trends in HIV infection in Michigan. This section provides an epidemiologic overview of HIV/AIDS in Michigan using secondary data sources.

3.1.1 HIV PREVALENCE IN MICHIGAN

Prevalence is the total number of persons currently living with a disease at one point in time. In Michigan, HIV prevalence estimates include persons diagnosed with HIV infection while residents of Michigan, regardless of current residence, and include the number of reported cases living with HIV infection, and the number of HIV infection cases that are not aware of their infection (estimated at 14% of the total cases living with HIV infection).

In 2014, there were an estimated 16,190 persons with HIV living in Michigan. Figure 6 presents prevalent HIV infection cases by county of residence in Michigan. In 2014, Wayne County had the greatest number of HIV cases (7,498 cases) and the highest rate of infection in Michigan (425 cases per 100,000). The City of Detroit accounted for 78% of cases in Wayne County which is a rate of 800 cases per 100,000 persons. Following Wayne County, the greatest numbers of diagnosed cases of HIV infection were in Oakland County (1,965), Kent County (920), Macomb County (802), Genesee County (546), Washtenaw County (552) and Ingham County (497). Ingham County had the second greatest rate of HIV infection (175 cases per 100,000) followed by Berrien County (163 cases per 100,000 persons), Oakland County (159 cases per 100,000), Washtenaw County (155 cases per 100,000), Kent County (146 cases per 100,000), Genesee County (132 cases per 100,000) and Kalamazoo County (132 cases per 100,000).

Figure 6: Prevalent HIV Infection Cases, by County of Residence at Diagnosis, Michigan, 2014

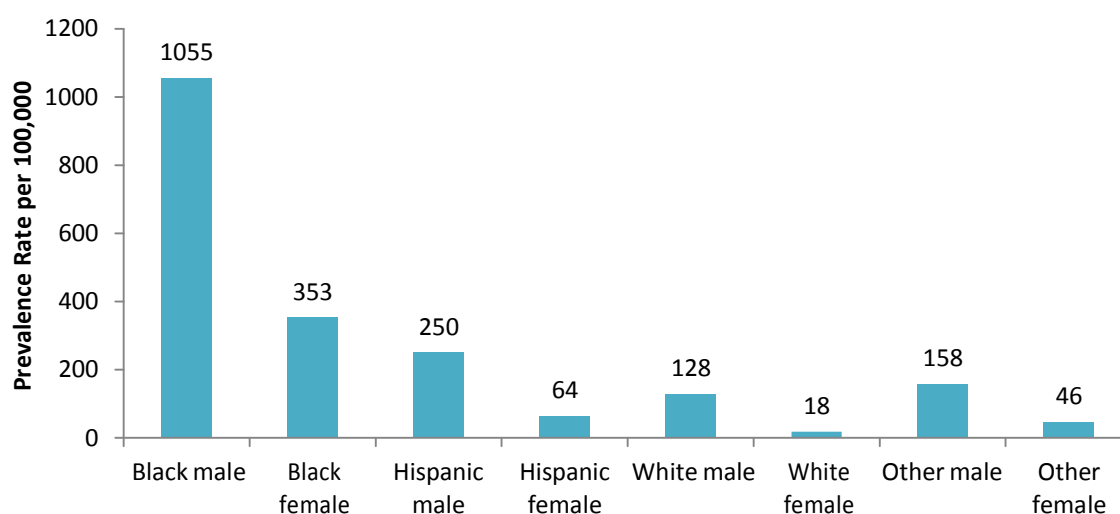


Note: Counties with less than 12 cases were suppressed

Source: Michigan Department of Community Health, HIV/STD/VH/TB Epidemiology Section, "Annual HIV Surveillance Report, Michigan, July 2015"

Figure 7 presents the HIV prevalence rate by race/ethnicity and gender. In Michigan, the HIV prevalence rate is highest for Black males (1,055 per 100,000), followed by Black females (353 per 100,000), Hispanic males (250 per 100,000), males of other racial groups (158 per 100,000) and White males (128 per 100,000). White females had the lowest prevalence of HIV, with a rate of 18 cases per 100,000 population.

Figure 7: HIV prevalence rate by race/ethnicity and sex, Michigan, 2013



Source: Michigan Department of Health and Human Services *Annual HIV Surveillance Report, Michigan*; Published July 2015.

Table 5 presents the distribution of HIV cases by age, gender, and race/ethnicity. In 2014, there were 12,666 males with HIV in Michigan. Among males with HIV, over 50% of cases were among Black men and nearly 40% of cases were among White men. The age distribution of HIV cases among men did vary by race/ethnicity. Among White men, a greater percentage were older than 30 years compared to other race/ethnic groups where more cases tended to be younger than 30 years.

There were 3,521 females with HIV in Michigan in 2014 (Table 5). Among females with HIV, over 70% of cases were among Black women and 20% of cases were among white women, with 4% of cases being among women of other/unknown race and 4% among Hispanic women. The age distribution among women with HIV did vary by race/ethnicity. There were a greater percentage of Black women who were over years compared to other racial groups and there were a greater percentage of women of Hispanic ethnicity 30 to 39 years of age compared to that of women in other race/ethnicity categories.

Table 5: Distribution of HIV cases by age, gender, and race/ethnicity Michigan, 2014

	White		Black		Hispanic		Other/ Unknown		Total	
	N	%	N	%	N	%	N	%	N	%
Males										
Total	4,733	37	6,912	55	604	5	417	3	12,666	100
0-12	23	<1	80	1	5	1	10	2	118	1
13-19	84	2	570	8	19	3	25	6	698	6
20-29	1,282	27	2,613	38	207	34	154	37	4,256	33
30-39	1,753	37	1,962	28	224	37	132	32	4,071	32
40-49	1,097	23	1,176	17	100	17	74	18	2,447	19
50-59	401	8	439	6	33	6	18	4	896	7
60+	93	2	72	1	11	2	4	1	180	1
Females										
Total	687	20	2,556	73	150	4	128	4	3,521	100
0-12	13	2	65	3	6	4	6	5	90	3
13-19	47	7	144	6	11	7	4	3	206	6
20-29	250	36	781	31	44	29	38	30	1,113	31
30-39	209	30	806	32	58	39	46	36	1,119	32
40-49	104	15	524	21	18	12	24	19	670	19
50-59	56	8	186	7	10	7	9	7	261	7
60+	8	1	50	2	3	2	1	1	62	2
MI Total	5,420	33	9,468	58	654	5	545	3	16,187	100

Source: Michigan Department of Health and Human Services *HIV Surveillance Report, Michigan*; Published July 2015

3.1.2. HIV TESTING

Early diagnosis of HIV infection is essential to ensure that persons are referred for evaluation, provided treatment, and linked into counseling and related support services to help them reduce their risk for transmitting HIV to others and improve health outcomes. In 2013, the U.S. Preventive Services Task Force (USPSTF) recommended that clinicians screen adolescents and adults ages 15 to 65 years for HIV infection. Younger adolescents and older adults who are at increased risk should also be screened. They recommend screening all pregnant women for HIV, including those who present in labor whose HIV status is unknown.

The Michigan Behavioral Risk Factor Surveillance System (BRFSS) is an annual, state-level telephone survey of Michigan residents, age 18 to 64 years. These annual, state-level surveys, act as the only source of state-specific, population-based estimates of the prevalence of various behaviors, medical conditions, and preventive health care practices among Michigan adults. In the 2013 cycle of the Michigan BRFSS, an estimated 41% of Michigan adults aged 18 to 64 years reported being tested for HIV infection at least once in their lifetime (Table 6). A greater proportion of females (44%) reported being tested compared to males (38%). Over 70% of Black, non-Hispanic adults reported having an HIV test, which was significantly greater than White, non-Hispanic adults (36%), Hispanic adults (41%), and adults of 'other' races (38%). A greater proportion of individuals who identified as being lesbian, gay, bisexual, or transgender (LGBT; 64%) reported being tested for HIV compared to individuals who did not identify as LGBT (41%).

Annually, the Michigan Department of Health and Human Services (MDHHS) receives funding from the Centers for Disease Control and Prevention (CDC) to support HIV counseling and testing as well as other prevention interventions. In 2014, MDHHS funded nearly 64,688 HIV tests for collaborating agencies (Table 7). The majority of tests were among men, African Americans, individuals aged 20 to 29 years, and those living in the Detroit Metropolitan Area (DMA).

Table 6: Ever had an HIV test by individual demographics, Michigan, 2013

	%
Total	41
Age	
18-24	27
25-34	54
35-44	57
45-54	42
55-64	28
Gender	
Male	38
Female	44
Race/Ethnicity	
White non-Hispanic	36
Black non-Hispanic	71
Other non-Hispanic	38
Hispanic	41
Health Insurance	
Insured	41
Uninsured	45
Sexual Orientation	
Not LGBT	41
LGBT	64
LGBT=Lesbian, Gay, Bisexual, or Transgender	
Source: Fussman C. 2014. Health Risk Behaviors in the State of Michigan: 2013 Behavioral Risk Factor Survey. 27 th Annual Report, Michigan Department of Health and Human Services,	

Table 8 presents race and gender of those who tested at MDHHS-funded counseling, testing, and referral (CTR) sites in Michigan. Of the over 60,000 tests that occurred, African American females accounted for 21,576 tests, which was 34% of the total number of tests performed in 2014. African American males accounted for 20,538 tests (33%). White males accounted for 10,864 tests (17%), White females accounted for 7,848 tests (13%), males of other racial groups accounted for 1,114 tests (2%), and females of other racial groups accounted for 607 tests (1%).

Table 9 presents agency demographics of the Counseling, Testing, and Referral (CTR) sites where tested occurred in Michigan. The CDC provides Category A funding for HIV prevention programs for health departments. Category A funded agencies, consisting of local health departments and MDHHS funded community based organizations (CBOs), accounted for 29% of testing that occurred in 2014. The CDC provides Category B funding for expanded HIV testing for disproportionately affected populations. Category B funded agencies, consisting of five agencies serving the City of Detroit (Advantage Health Centers, Detroit Community Health Connection, Detroit Referred Hospital, Henry Ford Health System, and Wayne State University), accounted for 71% of testing that occurred in 2014. Eighty-five percent of tests were in healthcare settings and 15% of tests were in non-healthcare settings; health care settings include those in which both medical diagnostic and treatment services are provided, while non-healthcare settings do not provide both medical diagnostic and treatment services and are also known as non-clinic settings. Specifically, 38% of tests occurred in STI clinics, 24% of tests occurred in emergency departments, 13% of tests occurred in primary care clinics, 11% of tests occurred in CBOs and service organizations, 6% of tests occurred in public health clinics, and 5% of tests occurred in non-healthcare settings. See glossary for definitions of CTR site types and settings.

Table 7: Individual demographics among persons who tested at Counseling, Testing and Referral sites, Michigan, 2014

	N	%
Gender		
Female	31,065	48
Male	33,270	51
Transgender	218	< 1
Unknown	135	< 1
Age (years)		
0-12	43	< 1
13-19	7,082	11
20-29	27,388	42
30-39	12,955	20
40-49	8,699	13
50-59	6,315	10
60+	2,206	3
Race		
African American	42,284	65
White	18,753	29
Other^	1,728	3
Unknown	1,923	3
Region		
DMA	43,546	67
Out State	21,142	33
MI Total	64,688	100
DMA=Detroit Metropolitan Area; Out State=Michigan excluding the DMA		
^Other race includes Arab, Asian, Native American, and Pacific Islander		
Source: Michigan Department of Health and Human Services, 2014		

Table 8: HIV testing at Counseling, Testing and Referral sites by race and gender, Michigan, 2014

	N	%
African American Female	21,576	34
African American Male	20,538	33
White Male	10,864	17
White Female	7,848	13
Other Male	1,114	2
Other Female	607	1
African American Transgender	169	< 1
White Transgender	41	< 1
Other Transgender	6	< 1
Total*	62,763	

^Other race includes Arab, Asian, Native American, and Pacific Islander
 *Individuals with unknown race were excluded from the analysis (n=1,923)
 Source: Michigan Department of Health and Human Services, 2014

Of the 64,688 funded tests performed in 2014, 64,024 tests (99%) were found to be negative, 475 tests were positive (0.7%), 185 tests had no result (0.3%), and 4 tests were indeterminate (Table 9). The percent positivity of tests among females (0.2%) was considerably lower than among males (1.2%) and transgender (5.0%). Tests performed among individuals age 20 to 29 years accounted for 42% of all tests and had a percent positivity of 0.9%. Tests performed among African Americans accounted for 65% of all tests and had a percent positivity of 0.9%. The percent positivity among Whites was 0.5% and 0.6% among individuals of other racial groups.

Category A funded agencies accounted for 71% of HIV tests and Category B agencies accounted for 15% of tests in 2014 (Table 10). The percent positivity of tests in Category A funded agencies (0.8%) was slightly higher than in Category B funded agencies (0.5%). Tests performed in healthcare settings accounted for 85% of all tests and had a percent positivity of 0.5%. Tests performed in non-healthcare settings accounted for 15% of tests and had a percent positivity of 2.0%. Agencies categorized as ‘other non-healthcare setting’ accounted for 5% of all tests performed but had the highest percent positivity (3.5%). Tests that occurred in ‘other healthcare settings’ accounted for less than 1% of all tests performed yet had the second highest percent positivity (2.7%). Tests performed at CBOs and other service organizations accounted for 11% of all tests and had a percent positivity of 1.2%. Tests performed in STI clinics accounted for 38% of all tests in 2014 and had a percent positivity of 0.5%. Emergency departments accounted for 24% of all tests and had a percent positivity of 0.4%.

Table 9: HIV testing at CTR sites by test result and individual and agency characteristics, Michigan, 2014

	No. HIV Tests Performed	% HIV Tests Performed	No. Positive Tests	% Positive Tests
MI Total*	64,688	100	475	0.7
Gender				
Female	31,065	48	55	0.2
Male	33,270	51	409	1.2
Transgender	218	< 1	11	5.0
Unknown	135	<1	0	0
Age				
0-12 years	43	0	1	2.3
13-19 years	7,082	11	24	0.3
20-29 years	27,388	42	238	0.9
30-39 years	12,955	20	95	0.7
40-49 years	8,699	13	58	0.7
50-59 years	6,315	10	49	0.8
60+ years	2,206	3	10	0.5
Race				
African American	42,284	65	361	0.9
White	18,753	29	100	0.5
Other^	1,728	3	11	0.6
Unknown	1,923	3	3	0.2
Funding				
Category A	45,731	71	388	0.8
Category B	18,957	29	87	0.5
Setting				
*Healthcare	54,756	85	278	0.5
**Non-Healthcare	9,928	15	197	2.0
Type				
Non-healthcare Settings	3,292	5	116	3.5
Healthcare Settings	226	< 1	6	2.7
CBOs and Service Organizations	7,039	11	85	1.2
Public Health Clinics	3,993	6	36	0.9
STI Clinics	24,566	38	132	0.5
Primary Care Clinics	8,402	13	41	0.5
Emergency Departments	15,380	24	57	0.4
Substance Abuse Treatment Facilities	1,778	3	2	0.1
Community Health Centers	12	< 1	0	0.0

^Other race includes Arab, Asian, Native American, and Pacific Islander

*Healthcare settings include: Local Health Departments, Clinics, Emergency Rooms, Federally Qualified Health Centers

**Non-Healthcare settings include: Community Based Organizations, Substance Abuse Treatment Facilities

Source: Michigan Department of Health and Human Services, Counseling, Referral, and Testing (CTR) Data, 2014

3.1.3. NEW DIAGNOSES IN MICHIGAN

New diagnoses of HIV infection are the number of newly diagnosed cases during a given period of time, usually a year. New diagnoses do not necessarily represent new infections, as newly diagnosed cases may have been infected for many years and therefore, can include all stages of disease. An estimated number of new diagnoses, resulting from statistical adjustment that account for reporting delays and missing transmission category, are presented in this section. These estimates may not be representative of all persons with HIV because not all infected persons have been tested, or were tested at a time when the infection could be detected and diagnosed. In addition, testing patterns are influenced by many factors, including the extent to which testing is routinely offered to specific groups, or the availability of, and access to, medical care and testing services. The data presented in this section provide a minimum estimate of persons for whom HIV infection has been diagnosed and reported during a given time period.

In 2013, the estimated rate of new diagnoses in Michigan was 8.1 per 100,000 population which is lower than the estimated U.S. rate of 15.0 per 100,000. Table 10 presents the distribution of estimated new diagnoses by gender, age, race, and transmission category. In Michigan, the majority of new HIV diagnoses in 2013 occurred in males (83%), African Americans (65%), and men who had sexual contact with other men (54%). Individuals age 20 to 29 years and those age 30 to 39 years accounted for nearly 60% of new diagnoses.

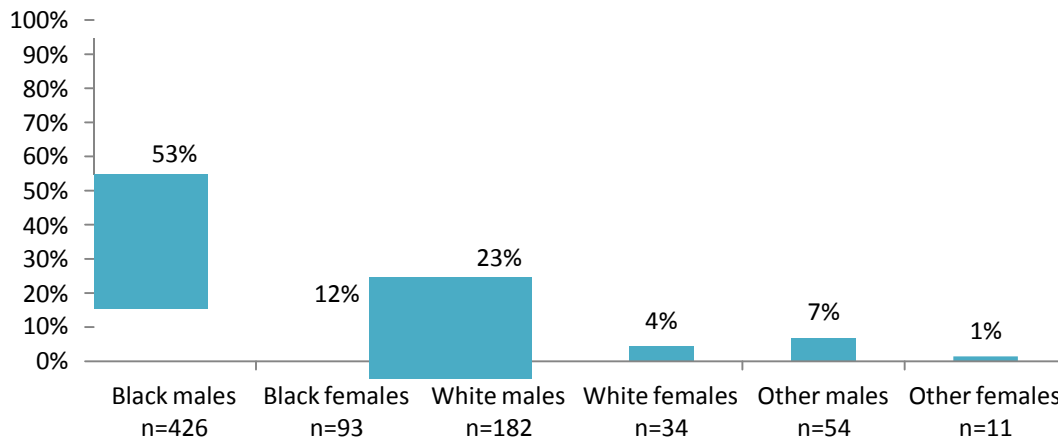
Table 10: Distribution of estimated new HIV diagnoses by age, gender, race, and transmission category, Michigan, 2013

	N	%
Gender		
Males	662	83
Females	138	17
Age		
13-19	63	8
20-29	308	39
30-39	156	20
40-49	137	17
50-59	95	12
60+	40	5
Race		
Black	519	65
White	215	27
Other	65	8
Transmission Category		
MSM	435	54
IDU	34	4
MSM/IDU	12	2
Heterosexual Contact	134	17
Other Known	4	1
No Identified Risk	181	23
MI Total	796	100

Source: Michigan Department of Health & Human Services, *Annual Review of HIV Trends in Michigan (2009-2013)*; Published April 2015.

Figure 8 displays estimated new diagnoses by race and gender. Black males (53%) accounted for more than half of the new diagnoses, followed by White males (23%), Black females (12%), and males of other racial groups (7%).

Figure 8: Estimated new diagnoses by race and gender, Michigan, 2013



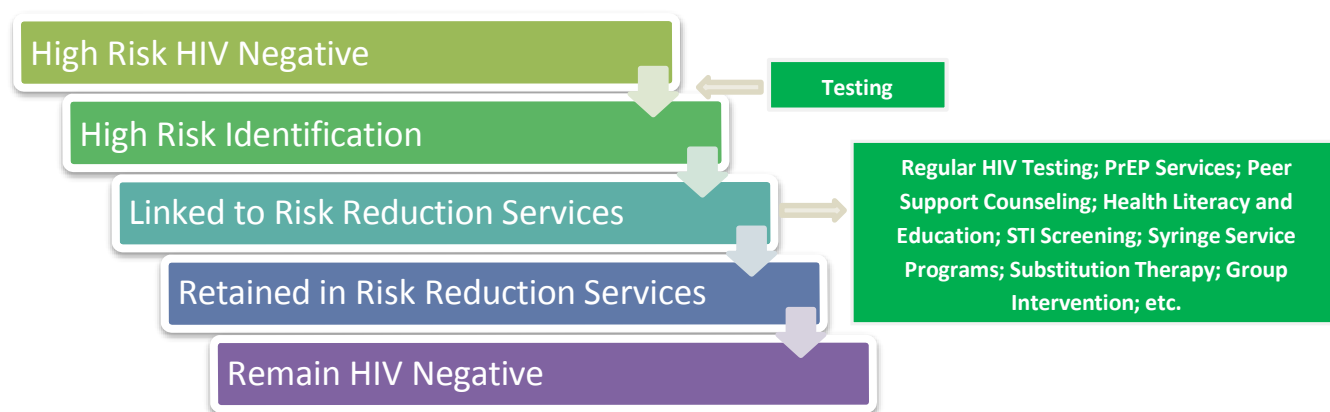
Source: Michigan Department of Health & Human Services, *Annual Review of HIV Trends in Michigan (2009-2013)*; Published April 2015.

Between 2009 and 2013 the rate of new diagnosis statistically significantly increased among white females (12%) and decreased among black females (7%). Among new males 20 years or older diagnosed between 2009-2013, 30% were Black MSM and 30% were Black non-MSM. However, among new males age 13-19 diagnosed between 2009-2013, 63% were Black MSM. There were no statistically significant increases of HIV infection by risk or age group.

3.1.4 THE PREVENTION CONTINUUM IN MICHIGAN

The HIV Prevention Continuum was created to help illustrate the series of stages a high risk, uninfected individual engages in from the initial identification of high risk behaviors through successful continuation of an HIV negative status. The HIV Prevention Continuum model has five stages including: uninfected individuals with high risk behaviors, the identification of individuals at high risk, linkage to risk reduction services, retention in risk reduction services, and continued HIV negative status (Figure 9). As part of the National HIV/AIDS strategy, recommended actions to prevent new HIV infections include targeting high risk populations, such as gay and bisexual men, African Americans, Latinos, and substance users, and ensuring that all HIV-negative people at high risk for HIV infection be tested for HIV and STIs annually and have access to behavioral and biomedical interventions and medical and social services with long term and sustainable outcomes that reduce the probability of HIV acquisition. Potentially, the HIV Prevention Continuum can be used to identify the proportion of individuals who are engaged at each stage and be used to identify issues and opportunities related to improving the delivery of these risk reduction services and reducing the number of new infections among high risk, uninfected individuals.

Figure 9: HIV Prevention Continuum for Uninfected Persons at High Risk



A. Indicators of Risk

Direct measures of risk provide information about risk behaviors that are directly associated with HIV transmission. Indirect measures do not directly describe HIV risk behaviors but serve as indicators of possible HIV risk that may need further investigation. Some direct and indirect risk behaviors that indicate HIV risk include sexual activity and practices, number of sex partners, sexual orientation, substance use, and the presence of other sexually transmitted infections.

Self-reported risk factors of persons testing at Counseling, Testing, and Referral (CTR) sites in Michigan are presented in Table 11. Although persons may have engaged in more than one risk behavior, having sex without a condom with a male or female partner (76%) and having sex while intoxicated and/or high on drugs (45%) were the most frequently reported risk behaviors. Three percent of persons reported using injection drugs and 3% of persons reported having sex with someone who injected drugs. Seven percent of men reported having sex with another man and less than one percent of females reported

having sex with a man who has sex with men. Two percent of persons reported having sex with someone who was HIV positive.

Table 11. HIV risk indicators among persons tested at CTR sites in Michigan, 2014

	N	%
No condom use	49,369	76
Sex while intoxicated and/or high on drugs	29,169	45
Man who has sex with a man	4,794	7
Exchanged sex for money/drugs/something else	2,353	4
Injecting Drug User	1,880	3
Sex with person who is an Injecting Drug User	1,686	3
Sex with person who is HIV+	1,141	2
Female who has sex with Man who has sex with a Man	274	< 1
Total Test Events	64,688	

Note: Categories are not mutually exclusive as persons can engage in multiple risk behaviors
Source: Michigan Department of Health and Human Services, Counseling, Referral, and Testing (CTR) Data, 2014

Among Michigan high school students surveyed in the Michigan Youth Behavior Survey, 38% reported having had sexual intercourse. Of Michigan students who reported having sexual intercourse in the previous three months, 39% reported not using a condom at last sexual intercourse and 21% reported drinking alcohol or using drugs before last sexual intercourse (Figure 10). Slightly more males (41%) reported having had sexual intercourse than females (36%). However, females (44%) were more likely to report not using a condom compared to males (33%). The proportion of White students (38%) and Black students (40%) who reported having sexual intercourse was fairly similar. White students were more likely to report not using a condom (41%) compared to Black students (29%) but slightly less likely to report drinking alcohol or using drugs before last sexual intercourse (20%) compared to Black students (24%).

Figure 10: Did not use condom* among high school students, Michigan, 2013



*Among students who had sexual intercourse during the past three months
Source: Michigan Department of Education, 2013 Youth Risk Behavior Survey

Injection drug use is a risk factor for HIV transmission and substance abuse has also been shown to be a risk factor for HIV transmission. Additionally, persons using illicit drugs and consuming large amounts of alcohol are at risk due to impaired judgment that may increase the chances of engaging in risky behaviors. The National Survey on Drug Use and Health (NSDUH) estimates that 11% of Michigan adolescents (12 to 17 years) and 24% of young adults (18 to 25 years) have used illicit drugs in the past month (Table 12). When marijuana use was excluded, illicit drug use decreased to 4% among adolescents and 7% among young adults. Binge alcohol use, which is drinking five or more drinks at the same time or within a couple hours of each other, was most commonly reported among young adults (42%) and those 26 years and older (24%). An estimated 17% of young adults have a dependence on illicit drugs or alcohol and 6% and 13% of young adults have needed treatment for illicit drug use and alcohol use but did not received it.

Table 12: Estimates of illicit drug use and alcohol use by age, Michigan, 2012-2013

	Age (years)		
	12 to 17	18 to 25	26 +
Illicit drug use*	11%	24%	9%
Illicit drug use other than marijuana*	4%	7%	3%
Binge alcohol use*	6%	42%	24%
Dependence or abuse of illicit drugs or alcohol^	6%	17%	8%
Needing but not receiving treatment for illicit drug use^	4%	6%	2%
Needing but not receiving treatment for alcohol use^	3%	13%	6%
*in past month			
^in past year			
Illicit drug use includes marijuana, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used non-medically; Binge alcohol use is defined as drinking five or more drinks on the same occasion (i.e., at the same time or within a couple of hours of each other) on at least 1 day in the past 30 days; Dependence or abuse is based on definitions found in the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV).			
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2012 and 2013.			

Sexually transmitted infection (STI) data are indirect indicators of HIV risk as they may serve as a surrogate marker for unsafe sexual practices in a specific population. Individuals who are infected with STIs are more likely than uninfected individuals to acquire HIV infection if they are exposed to the virus through sexual contact. In addition, HIV infected individuals also infected with another STI are more likely to transmit HIV through sexual contact than other HIV infected persons.

The rate of Chlamydia infection in Michigan is 456 per 100,000 population (Table 13). The rate of gonorrhea infection in Michigan is 107 per 100,000 population. The rate of syphilis for all stages is 11 per 100,000 and for primary and secondary syphilis is 5 per 100,000. Syphilis is more common among men. Females are almost 2.5 times more likely to have chlamydia compared to men.

Table 13. Rates of Sexually Transmitted Infections, Michigan, 2013

	Total	Male	Female
Chlamydia	456	263	641
Gonorrhea	107	97	116
Syphilis (all stages)	11	19	4
Primary & Secondary Syphilis	5	10	1
Rate per 100,000			
Source: Michigan Sexually Transmitted Infections Database, Michigan Department of Health and Human Services			

The number of chlamydia and gonorrhea cases is highest among 20-22 year olds. Primary and secondary syphilis cases are fairly evenly distributed among 20-24 year olds (32%), 25-29 year olds (20%), and 30-44 year olds (29%). The highest ranked local health departments by chlamydia rate were Detroit, Muskegon, Genesee, Kalamazoo and Saginaw. For gonorrhea the highest ranked local health departments by rate were Detroit, Genesee, Muskegon, Calhoun, and Berrien. Based on 498 gonorrhea interviews, nearly 30% of cases had a previous STI history, and over 30% of males and nearly 20% of females reported having sex while drunk or high. Over 20% of male cases reported having anonymous partners. The mean number of partners in the preceding 12 months was 5 partners for males with chlamydia, 4 for females with chlamydia, 7.5 for males with gonorrhea and 4 for females with gonorrhea.

All syphilis cases are more likely to be among those 30-44 year olds (31%). The male: female ratio for primary and secondary syphilis cases is 15.6:1. 63% of primary and secondary syphilis cases were among black males. In 2013, statewide, of the 465 male cases, 374 (80%) were MSM. In 2013, 39% of primary and secondary syphilis cases outside of the Detroit area had HIV as well as syphilis.

Figure 11. Primary and Secondary Syphilis Rates by Local Health Jurisdiction, Michigan, 2013

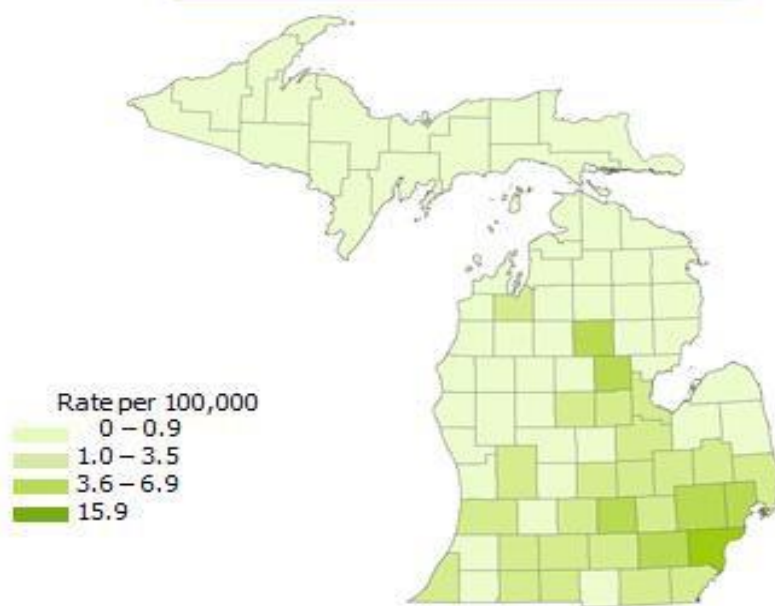


Figure 12. Chlamydia Rates by Local Health Jurisdiction, Michigan, 2013

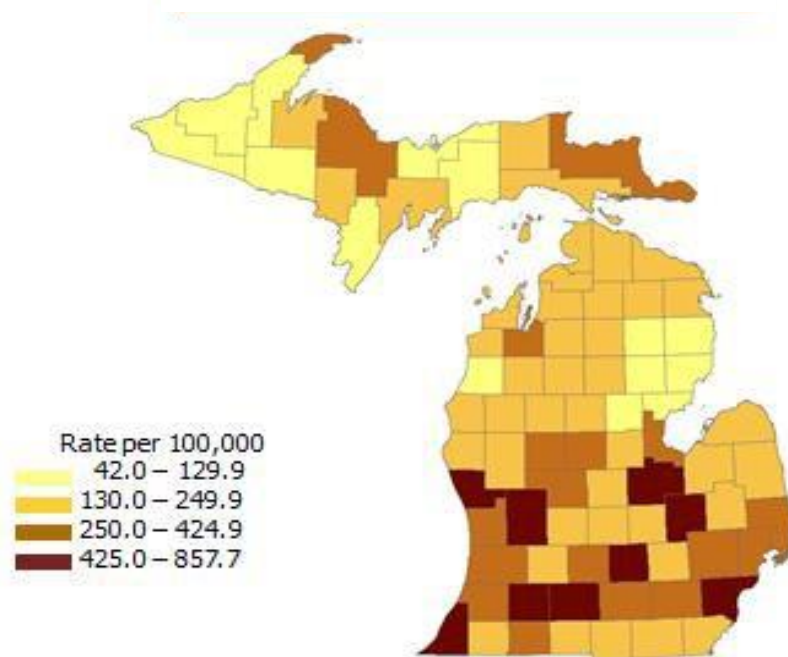
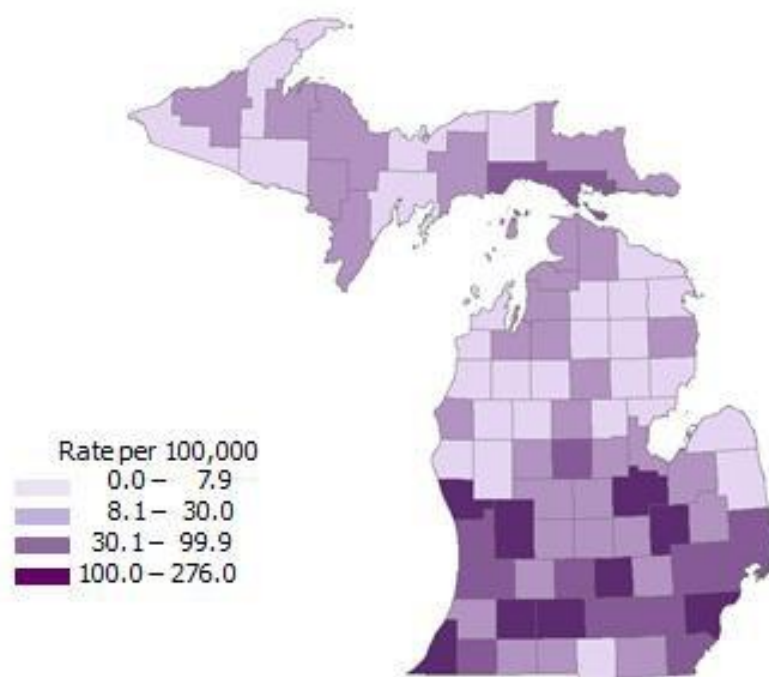


Figure 13. Gonorrhea Rates by Local Health Jurisdiction, Michigan, 2013



B. HIV Transmission Category

HIV Transmission categories were created for summarizing the multiple risk factors that a person may have had by selecting the one most likely to have resulted in HIV transmission. For surveillance purposes, persons with more than one reported risk factor for HIV infection are classified in the transmission category listed first in a hierarchy of transmission categories, and therefore counted once. The exception is men who have sexual contact with other men and injected drugs; this group makes up a separate transmission category.

Table 14 presents the mode of HIV transmission by gender and race/ethnicity. Among males, the most common mode of HIV transmission was through male to male sex (67%). This was similar for each race/ethnicity group, however a greater percentage of Black and Hispanic men (7% and 7%) contracted HIV infection through injection drug use compared to White men (3%). Among females, the most common mode of HIV transmission was through heterosexual contact (68%). A greater percentage of Black women and women of other/unknown race (16% and 17%) contracted HIV infection through undetermined modes compared to white women and Hispanic women (10% and 6%).

Table 14: Mode of HIV transmission by gender and race/ethnicity Michigan, 2014

	White		Black		Hispanic		Other/ Unknown N		Total	
	N	%	N	%	N	%			N	%
Males										
Total	4,733	37	6,914	55	604	5	417	3	12,668	100
Male-Male Sex	3,620	76	4,227	61	380	63	256	61	8,483	67
IDU	159	3	515	7	41	7	24	6	739	6
MSM/IDU	259	5	284	4	17	<1	28	7	588	5
Blood Products	52	1	13	<1	1	<1	1	<1	67	1
HC	129	3	452	7	45	7	14	3	640	5
Perinatal	13	<1	76	1	5	1	9	2	103	1
Undetermined	501	11	1,347	19	115	19	85	20	2,048	16
Females										
Total	688	20	2,556	73	150	4	128	4	3,522	100
IDU	117	17	370	14	23	15	17	13	527	15
Blood Products	7	1	3	<1	1	1	0	0	11	<1
HC	480	70	1,705	67	111	74	83	65	2,379	68
Perinatal	12	2	61	2	6	4	6	5	85	2
Undetermined	72	10	417	16	9	6	22	17	520	15

IDU=Injection drug use; MSM=Male to Male Sex; HC=Heterosexual contact

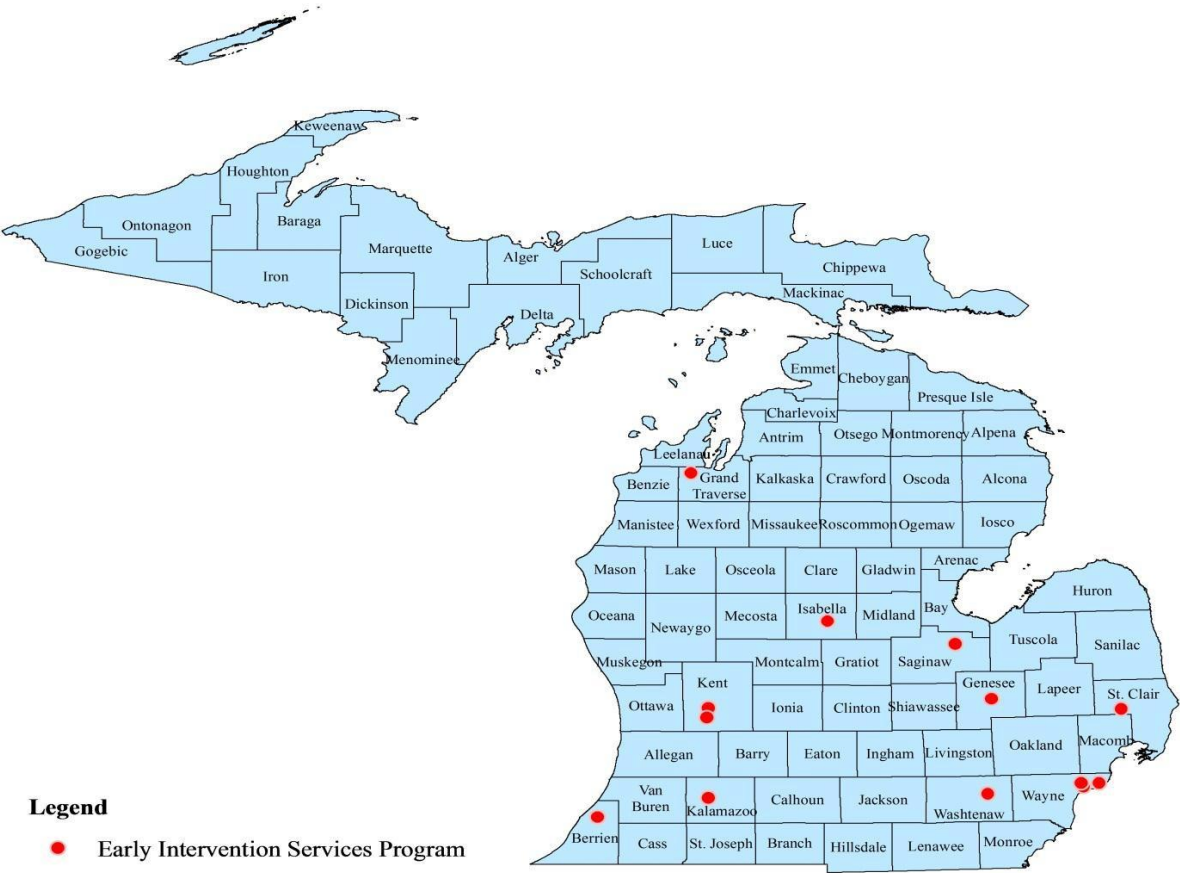
Source: Michigan Department of Health and Human Services, *Annual HIV Surveillance Report, Michigan*;

Published July 2014

C. Early Intervention Services in Michigan

HIV Early Intervention Services (EIS) is a program funded through the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA). EIS was established to support the incorporation of HIV prevention into the medical care of persons living with HIV and was created to prevent new HIV infections, increase the proportion of persons with HIV who are aware of their infection, prevent HIV-related illness and death, and reduce HIV-related health disparities. The program consists of biomedical, behavioral, and structural interventions that can help reduce the risk of HIV transmission from persons with HIV by reducing their infectiousness and their risk of exposing others to HIV. In order for an individual to be eligible for these services, an individual must meet the following criteria: 1). HIV-positive, 2). resident of Michigan, 3). income level that does not exceed 450% of the Federal Poverty Level, and 4). underinsured or uninsured for applicable Ryan White services that are reimbursable through third party payers.

Figure 14: HIV Early Intervention Services, Michigan

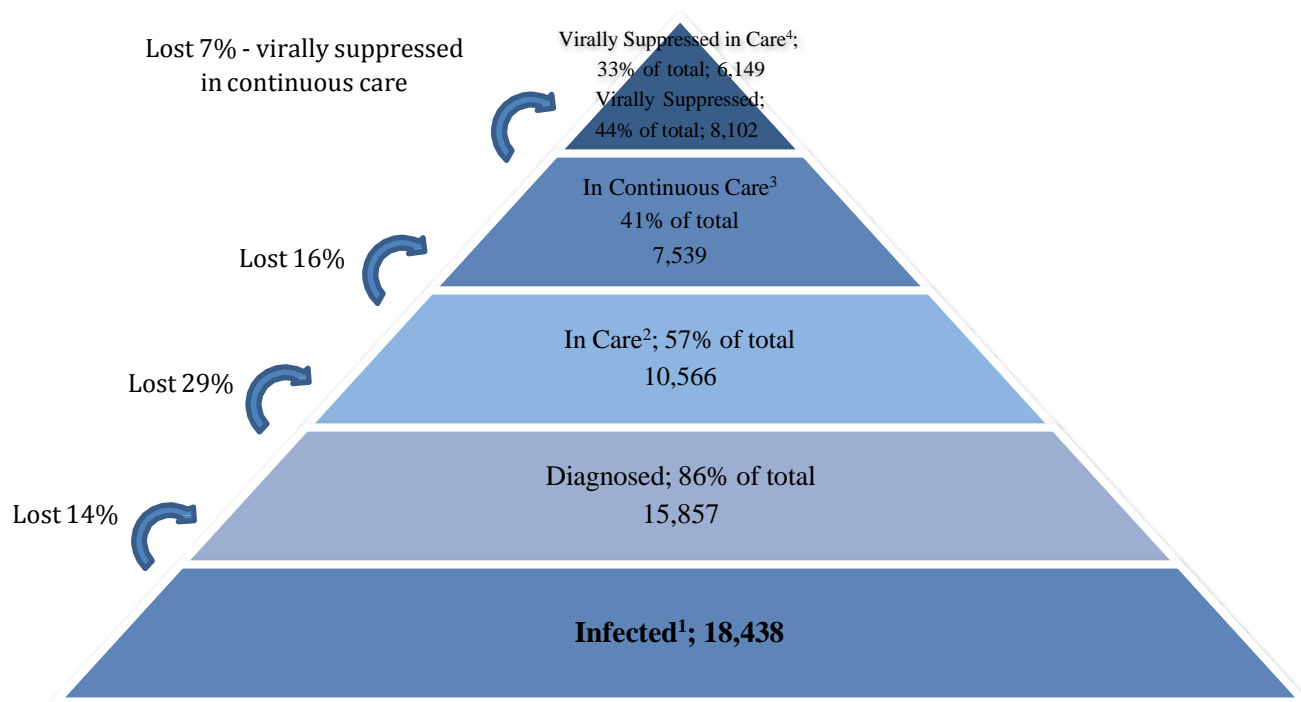


Michigan Department of Health and Human Services and Ryan White Part C Funded Early Intervention Services Providers, as of 02/06/2015

3.1.5. THE CARE CONTINUUM IN MICHIGAN

The HIV Care Continuum is a model that outlines the sequential stages of HIV medical care that people living with HIV go through from initial diagnosis to achieving the goal of viral suppression. The HIV Care Continuum has five stages and is used to show the proportion of individuals living with HIV who are engaged in each stage. The five stages include: those aware and unaware of their HIV infection, HIV diagnosis, linkage to care, retention in care, and viral suppression. The prevalence-based model shows each step of the continuum as a percentage of the total number of people living with HIV. This approach was used so that the care continuum for all people living with HIV in Michigan can be examined. This method allows for monitoring of broad populations, such as African Americans or men who have sex with men, overall. The HIV Care Continuum for Michigan is presented in Figure 15.

Figure 15: HIV Care Continuum, Michigan, 2013



¹Persons aware and unaware of their infection; based on National estimate that 14% of PLWHA are unaware of their infection.

²In care: PLWH with at least one CD4, viral load (VL), and /or genotype lab test during the given year

³In continuous care: PLWH who received at least two CD4, viral load (VL), and/or genotype lab tests with the given year at least three months apart; gained 3% virally suppressed

⁴Virally suppressed in care: PLWH in continuous care whose most recent viral load test had less than or equal to 200 copies of HIV virus per milliliter of blood; 1,953 persons were virally suppressed but not in continuous care during the year

Source: Michigan Department of Health and Human Services, *Michigan HIV Care Continuum, Annual Report, 2015*.

A. Unaware

In 2013, approximately 14% of the estimated 18,438 people living with HIV infection in Michigan were undiagnosed. Late HIV Diagnosis, or concurrent diagnosis, is diagnosis with both HIV infection and Stage 3 (AIDS) infection within 30 days. This diagnosis is likely to occur in people who have been infected for some time prior to learning of their status and are therefore late to access HIV-related care and support. These individuals represent a population who are unaware of their HIV infection and may not experience the full benefits of these services, including improved health, better quality of life, longer survival, and reduction in the likelihood of transmitting HIV to others. In Michigan, of the estimated 800 newly diagnosed cases of HIV infection in 2013, approximately 26% were diagnosed at Stage 3 (AIDS) (Table 15). A greater percentage of men (27%) were diagnosed at a later stage than women (22%) and Whites (30%) and persons of other racial groups (29%) were more likely than Blacks (24%) to be diagnosed at a later stage.

Table 15: Late HIV diagnosis, Michigan, 2013

	Stage 3 (AIDS) Diagnosis within 30 Days of Diagnosis	Persons Newly Diagnosed	Late HIV Diagnosis
All	209	800	26%
Gender			
Male	179	662	27%
Female	30	138	22%
Race			
White	64	215	30%
Black	125	519	24%
Other	19	65	29%

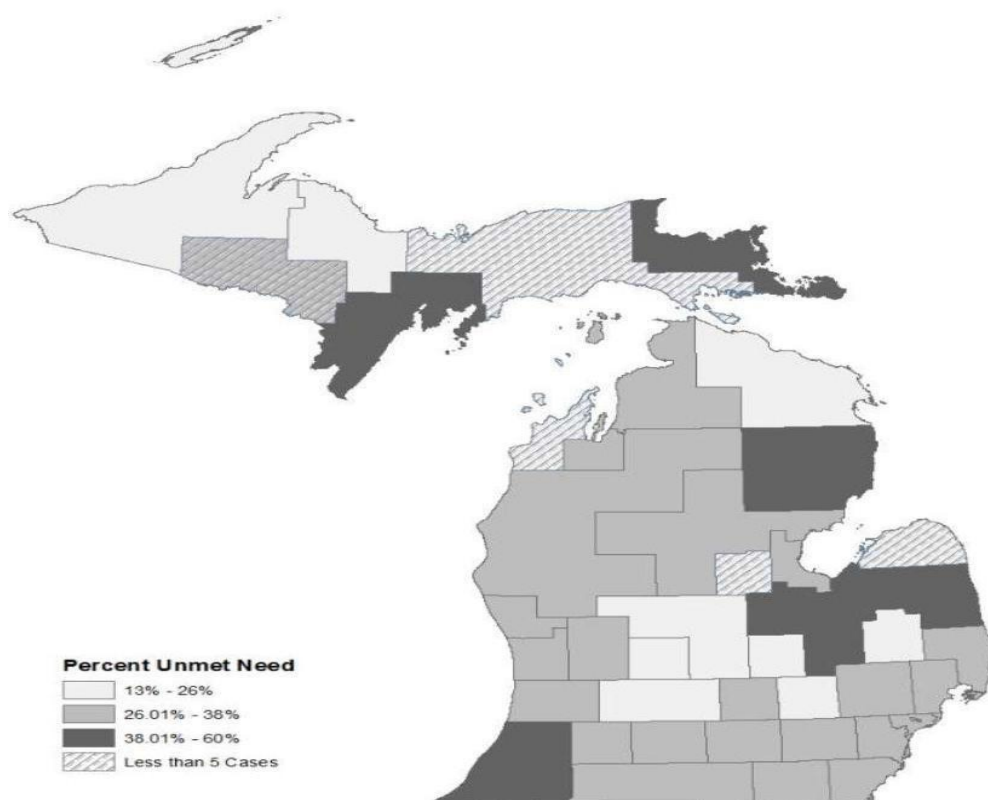
Source: Michigan Department of Health & Human Services, *Annual Review of HIV Trends in Michigan (2009-2013)*; Published April 2015

B. HIV Medical Care: Linkage and Retention

In 2013, approximately 29% of the estimated 15,857 people diagnosed with HIV infection in Michigan were not linked to any HIV medical care. Additionally, 16% of the estimated 10,566 persons who were linked to care were not being retained in HIV medical care. The need for HIV related health services by individuals with HIV who are aware of their HIV status, but are not receiving regular primary care is defined as unmet need by the Health Resources and Services Administration (HRSA). Analysis for unmet need for medical services among people living with HIV/AIDS was conducted in 2015 by the Michigan Department of Health and Human Services (MDHHS) during the 12-month time period of October 1, 2013 to September 20, 2014. Of persons living with HIV in Michigan as of September 30, 2014 who were diagnosed with HIV by October 1, 2013, approximately 35% had an unmet need, which means that they did not have a medical visit which included a CD4 count, viral load, or HIV related prescription for medication during the year. Injection drug users (IDU), men who have sex with men and also inject

drugs (MSM/IDU), Hispanic men and women, persons 65 years and older, and persons 35 to 39 years of age were the population groups in Michigan with the highest levels of unmet need. In 2014, unmet need was analyzed by local health department jurisdiction in Michigan (Figure 16). Berrien County had the highest proportion of unmet need (46%), followed by Genesee County (40%), Bay, Saginaw, Midland counties (40%), and Monroe County (38%).

Figure 16: Percent unmet need by local health department jurisdiction, Michigan



Note: Unmet need was calculated by determining the number of persons living with HIV infection in Michigan who were diagnosed prior to October 1, 2012 and had not received a CD4 test or viral load between October 1, 2012 and September 30, 2013.

Source: Michigan Department of Health and Human Services, *2014 Epidemiological Profile of HIV in Michigan*

C. Viral Suppression

Achieving viral suppression is defined as having an HIV viral load of less than 200 copies/mL at last test. Suppressed levels of the HIV virus allow people living with HIV to live longer and healthier lives and decreases the likelihood of transmitting HIV to others. Of the estimated 18,438 people living with HIV (diagnosed and undiagnosed) in Michigan, in 2013, only 30% to 40% achieved viral suppression. This is due to persons with HIV having not been diagnosed, not linked to HIV medical care, and not taking HIV medications. Of individuals in HIV medical care, over 80% achieve viral suppression.

Of those with diagnosed HIV infection, approximately 51% of individuals in Michigan achieve viral suppression (Table 16). Compared to the overall percentage in Michigan, a greater proportion of men who have sex with men achieve viral suppression (53%). Less than half of African Americans (48%) and only 41% of Latinos achieved viral suppression in 2013. The proportion of persons with viral suppression increases as age increases (Table 17). In 2012, only 36% of persons 13 to 19 years and 37% of persons 20 to 29 years were virally suppressed.

Table 16: Viral suppression by population group, Michigan, 2013

Population	Diagnosed HIV	Virally Suppressed	
	N	N	%
African American	8,774	4,185	48
Latino	832	337	41
MSM	8,950	4,780	53
MI Total	15,857	8,102	51
Populations are not mutually exclusive			
Source: Michigan Department of Health and Human Services, <i>Implementing The National HIV/AIDS Strategy (NHAS) in Michigan, January 2015.</i>			

Table 17: Viral suppression by age group, Michigan, 2012

Age (years)	Diagnosed HIV	Virally Suppressed	
	N	N	%
13 to 19	163	58	36%
20 to 29	1900	697	37%
30 to 39	2755	1238	45%
40 to 49	5140	2502	49%
50 to 59	3882	2071	53%
60 +	1402	737	53%
3 persons had missing age			
Source: Michigan Department of Health and Human Services, 2014 <i>Epidemiological Profile of HIV in Michigan</i>			

Table 18 presents viral suppression by Metropolitan Statistical Area (MSA) in Michigan. Only 33% of HIV positive persons residing in the Benton Harbor MSA had achieved viral suppression. Additionally, the Saginaw, Bay, Midland MSA (40%) and the Flint MSA (41%) had low proportions of HIV positive residents with viral suppression. The Lansing MSA, which consists of Clinton, Eaton, and Ingham counties, had the greatest proportion of residents with viral suppression (58%), as well as the Kalamazoo-Battle Creek MSA (56%), the Grand Rapids, Muskegon, Holland MSA (56%), and the Ann Arbor MSA (56%).

Table 18: Viral suppression by Metropolitan Statistical Area (MSA), Michigan, 2013

Metropolitan Statistical Area (MSA)	Diagnosed HIV	Virally Suppressed [^]	
	N	N	%
Benton Harbor MSA	253	83	33
Saginaw, Bay, Midland MSA	345	137	40
Flint MSA	536	219	41
Detroit Metro Area	9969	5,012	50
Jackson MSA	183	94	51
Ann Arbor MSA	602	335	56
Grand Rapids, Muskegon, Holland MSA	1396	785	56
Kalamazoo-Battle Creek MSA	551	306	56
Lansing MSA	608	350	58

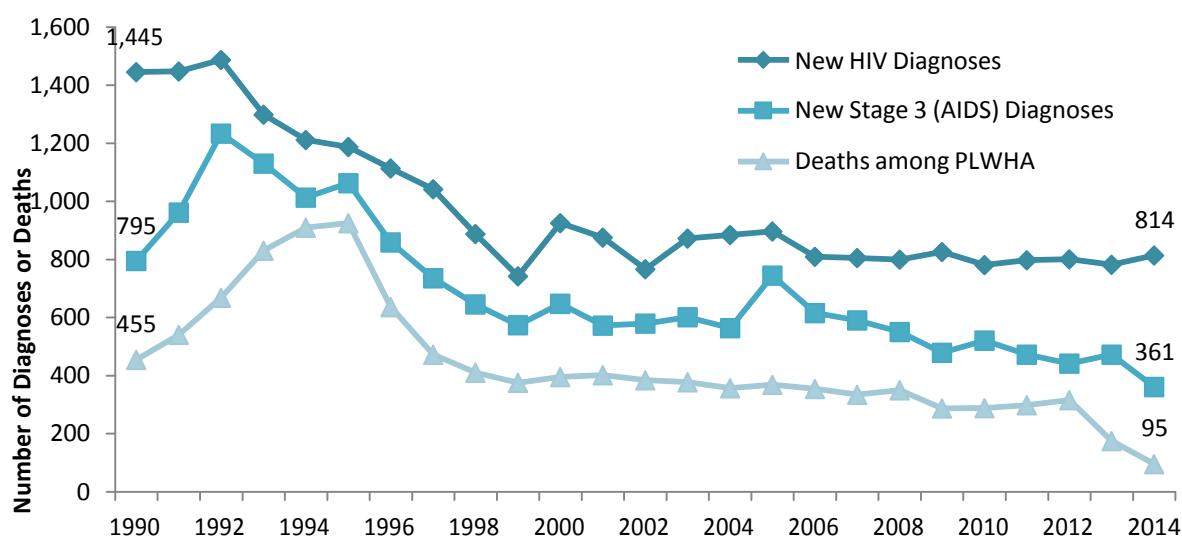
[^]Persons with a viral load of < 200 copies/mL; includes those in continuous care and not in continuous care during the given year

Source: Michigan Department of Health and Human Services, *Metropolitan Statistical Area (MSA) HIV Care Continuum*, January 2015

3.1.6. TRENDS IN THE MICHIGAN HIV/AIDS EPIDEMIC

The number of reported cases of HIV and AIDS in Michigan declined significantly since 1990 (Figure 17). Since 1990, new diagnoses of HIV infection decreased by 44%. Diagnoses of Stage 3 HIV Infections (AIDS) peaked in 1992 and declined by 70% due to the advent of highly effective antiretroviral medications. In the last 5 years, the number of new HIV diagnoses has declined by 1% and the number of Stage 3 (AIDS) diagnoses declined by 25%. The number of deaths of HIV infected persons peaked in 1995, saw a sharp decline, and has slowly declined since 2000.

Figure 17: Trends in HIV/AIDS diagnoses and deaths, Michigan, 1990-2014

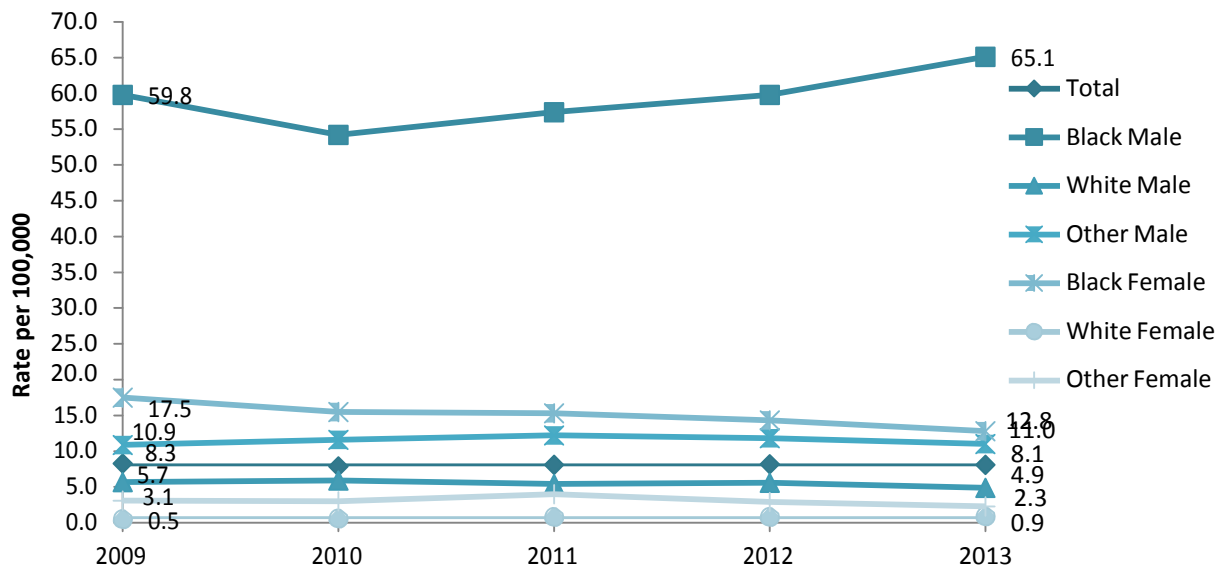


*Reported deaths for most recent years may not be complete

Source: Michigan Department of Health and Human Services, Bureau of Disease Control, Prevention and Epidemiology, HIV/STI/Viral Hepatitis. *Annual HIV Surveillance Report, Michigan*; Published July 2015

The overall rate of new diagnoses in Michigan is 8.1 per 100,000 and has remained fairly stable since 2009 (Figure 18). The rate of new HIV diagnoses among African American males, which is the highest rate for among any other race/gender group, increased from 59.8 per 100,000 in 2009 to 65.1 per 100,000 in 2013. The rate among African American females, which is the second highest rate, decreased from 17.5 per 100,000 in 2009 to 12.8 per 100,000 in 2013. Rate decreases also occurred among White males and women of other racial groups. The rate among White women, who have the lowest rate of new HIV diagnosis, increased from 0.5 per 100,000 in 2009 to 0.9 per 100,000 in 2013.

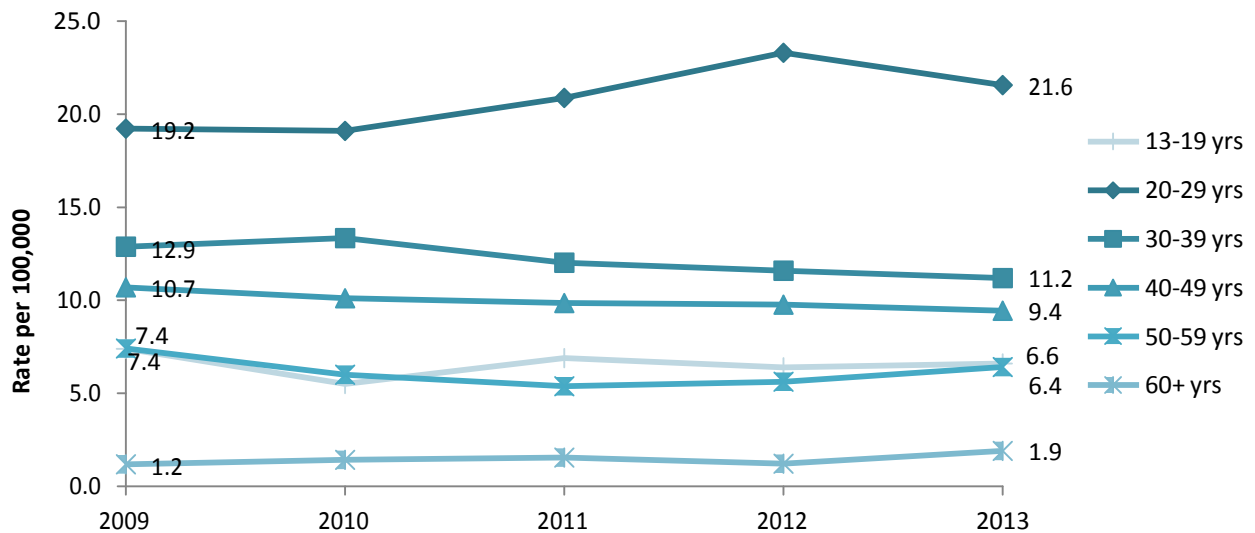
Figure 18: New diagnoses by race and gender, Michigan, 2009-2013



Source: Michigan Department of Health and Human Services, Bureau of Disease Control, Prevention and Epidemiology, HIV/STI/Viral Hepatitis. Annual Review of HIV Trends in Michigan (2009-2013); Published April 2015

As seen in figure 19, persons 20 to 29 years of age have the highest rate of new HIV diagnosis (21.6 per 100,000), a rate that has increased since 2009 (19.2 per 100,000). The rate of new diagnoses among persons age 60 years and older increased from 1.2 per 100,000 in 2009 to 1.9 per 100,000 in 2013. The rate of new HIV diagnoses among all other age groups declined.

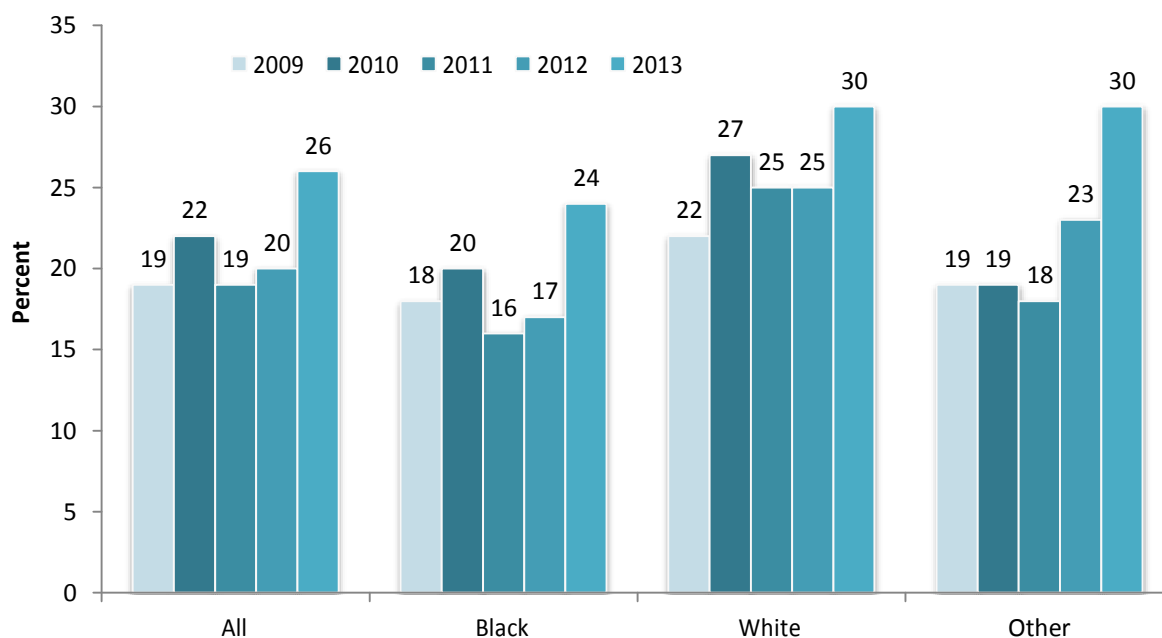
Figure 19: New diagnoses by age, Michigan, 2009-2013



Source: Michigan Department of Health and Human Services, Bureau of Disease Control, Prevention and Epidemiology, HIV/STI/Viral Hepatitis. Annual Review of HIV Trends in Michigan (2009-2013); Published April 2015

Concurrent diagnosis, diagnosis with both HIV infection and Stage 3 (AIDS) within 30 days, is likely to occur in people who have been infected for some time prior to learning of their status and are therefore late to access HIV-related care and support. These individuals represent a population who are unaware of their HIV infection and may not experience the full benefits of these services, including improved health, better quality of life, longer survival, and reduction in the likelihood of transmitting HIV to others. Overall, the proportion of persons diagnosed with Stage 3 (AIDS) within 30 days of diagnosis increased from 19% in 2009 to 26% in 2013 (Figure 20). Even though concurrent diagnosis increased for each racial group, in 2013, Whites and persons of other racial groups have the highest proportion of concurrent diagnosis.

Figure 20: Concurrent diagnosis by race, Michigan, 2009-2013



Source: Michigan Department of Health and Human Services, Bureau of Disease Control, Prevention and Epidemiology, HIV/STI/Viral Hepatitis. Annual Review of HIV Trends in Michigan (2009-2013); Published April 2015

The proportion of concurrent diagnosis increased for both men and women since 2009. In 2013, 27% of men had a concurrent diagnosis compared to 21% of women (Figure 21).

Figure 21: Concurrent diagnosis by gender, Michigan, 2009-2013



Source: Michigan Department of Health and Human Services, Bureau of Disease Control, Prevention and Epidemiology, HIV/STI/Viral Hepatitis. Annual Review of HIV Trends in Michigan (2009-2013); Published April 2015

SECTION 3.1 SUMMARY: THE SCOPE OF HIV INFECTION IN MICHIGAN

- In 2014, there were an estimated 16,190 persons living with HIV in Michigan. Wayne County had the greatest number of HIV cases and the highest rate of persons living with HIV in Michigan. The City of Detroit accounted for 78% of HIV cases in Wayne County, which was a rate of 800 cases per 100,000 population.
- Black/African American residents were disproportionately impacted by HIV infection in Michigan. Black males accounted for the greatest number of HIV cases in Michigan, with a rate of 1,055 cases per 100,000 population. Black females accounted for the second highest number of HIV cases in Michigan, with a rate of 353 cases per 100,000 population.
- In 2014, 64,688 tests occurred at a MDHHS designated testing sites. The majority of tests performed were among men, African Americans, individuals aged 20 to 29 years, and those living in the DMA. Of tests performed, 99% were negative and less than 1 percent were positive. Category A funded agencies accounted for 71% of all tests and had a percent positivity of 0.8%. Category B funded agencies accounted for 15% of all tests and had a percent positivity of 0.5%. Category A funds HIV prevention programs for health departments, while Category B funds expanded HIV testing for disproportionately affected populations.
- There were an estimated 800 new diagnoses of HIV in Michigan in 2013. Of those newly diagnosed, 83% were male, 39% were 20 to 29 years, 65% were black, and 54% were men who had sex with men.
- Male to male sexual contact is the leading mode of transmission for HIV among males, followed by undetermined modes and injecting drug use. Heterosexual contact is the leading mode of transmission for HIV among women, followed by injecting drug use and undetermined modes.
- In 2014, an estimated 35% of persons living with HIV in Michigan had an unmet need. A greater percentage of injection drug users, men who had sex with men and inject drugs, Hispanic men and women, persons 65 years and older, and persons 35 to 39 years had unmet need compared to other population groups.
- Berrien County had the highest proportion of unmet need, followed by Genesee County, Bay, Saginaw, and Midland counties, and Monroe County.
- A greater proportion of men who have sex with men achieve viral suppression compared to other population groups. Less than half of African Americans and only 41% of Latinos achieved viral suppression in 2013. Only 36% of persons 13 to 19 years and 37% of persons 20 to 29 years were virally suppressed in 2012.
- Overall, rates of new diagnoses in Michigan have remained stable since 2009. Rates of new HIV diagnoses have increased among Black males and white females. Decreased rates were seen among Black females, white males, and women of other racial groups.
- The proportion of persons with concurrent diagnoses, or those diagnosed with Stage 3 (AIDS) within 30 days of HIV diagnosis, increased from 19% in 2009 to 26% in 2013. Whites and persons in other racial groups had the highest proportion of concurrent diagnoses.

3.2. SURVEY OF PERSONS LIVING WITH HIV/AIDS IN MICHIGAN

As the first part of the Themes and Strengths portion of the MAPP assessment (see Section 1.1 Needs Assessment Process), a statewide, in-person survey was conducted among persons living with HIV/AIDS. The purpose of this survey was to supplement and address gaps in existing secondary data within the state. An original survey, consisting of a mix of multiple choice and open-ended questions, was developed by MPHI with feedback and input from the Themes and Strengths and Steering Committees. Survey topics included HIV testing and diagnosis, partner services, initial linkage to medical care and care services, initial linkage to a case manager and support services, current use of medical care and support services, HIV medications, viral suppression, services needed, PrEP knowledge and attitudes, and suggestions for service improvement. However, because survey data were not a random sampling of the population, data does not represent the population as a whole and cannot be generalizable. A major limitation here is that this data is not representative and excludes clients from the west side of Michigan. This data should be used in addition to secondary data sources. A copy of the survey tool can be found in the Appendix.

The counties for recruitment were selected based on the prevalence of HIV infection, the proportion of unmet need and the proportion of the population who are virally suppressed. We also added several counties from northern Michigan in order to have geographic representation from across the state. Recruitment efforts were targeted to: Wayne, Oakland, Genesee, Saginaw, Berrien, Grand Traverse and Marquette counties. Participants were recruited from local health departments, HIV/AIDS service organizations (ASOs), community based organizations (CBOs), HIV/AIDS support groups, testing facilities, Ryan White providers, bars and social settings as referred by members of the Steering and Subcommittee members. Organizations were asked to target recruitment efforts to persons living with HIV from specific groups (e.g., young black men who have sex with men, transgender individuals, injecting drug users, individuals who were recently out of care, etc.). Several organizations and support groups were chosen as recruitment locations because their primary client population represented one of our targeted groups.

Surveys were administered during July and August in a private location by trained interviewers, or self-administered if a participant preferred to do so. The consent process and administration of the survey took anywhere from 45 minutes to 1 hour and respondents were provided a \$20 Visa gift card for their time. Data from multiple choice questions were analyzed using the Statistical Package for the Social Sciences (SPSS) and are presented using descriptive statistics. Surveys were not audio-recorded, thus all answers to open-ended questions consisted of notes written by interviewers or participants with few verbatim, direct quotes. Data from open ended questions were coded and organized into themes. Responses under each theme were enumerated and themes were presented in rank order.

The research protocol, informed consent script, and survey tool were approved by the Institutional Review Board (IRB) at the Michigan Public Health Institute in Okemos, Michigan and the Michigan Department of Health and Human Services IRB in Lansing, Michigan.

3.2.1 DEMOGRAPHICS AMONG SURVEY PARTICIPANTS LIVING WITH HIV/AIDS IN MICHIGAN

Trained survey administrators traveled to recruitment sites throughout the state and administered a total of 191 surveys with participants representing 21 Michigan counties. Reflecting the geographical burden of HIV in Michigan, more than half of participants (56%) were recruited from Wayne and Oakland counties within the Detroit Metropolitan Statistical Area (DMA, comprised of Wayne, Oakland, Lapeer, Macomb, Monroe and St. Clair counties), while 40% were recruited from counties in out-state Michigan (comprised of all counties excluding those within the DMA); the remaining 4% were missing data. Figure 19 presents the counties in which primary data were collected among persons living with HIV/AIDS. Throughout this section, data will be presented for all of Michigan, including both the DMA and out-state counties, and solely for out-state counties excluding the DMA; data representing only the DMA are presented in Section 6.2 of this document.

Figure 22: County of residence among persons living with HIV/AIDS surveyed, Michigan 2015

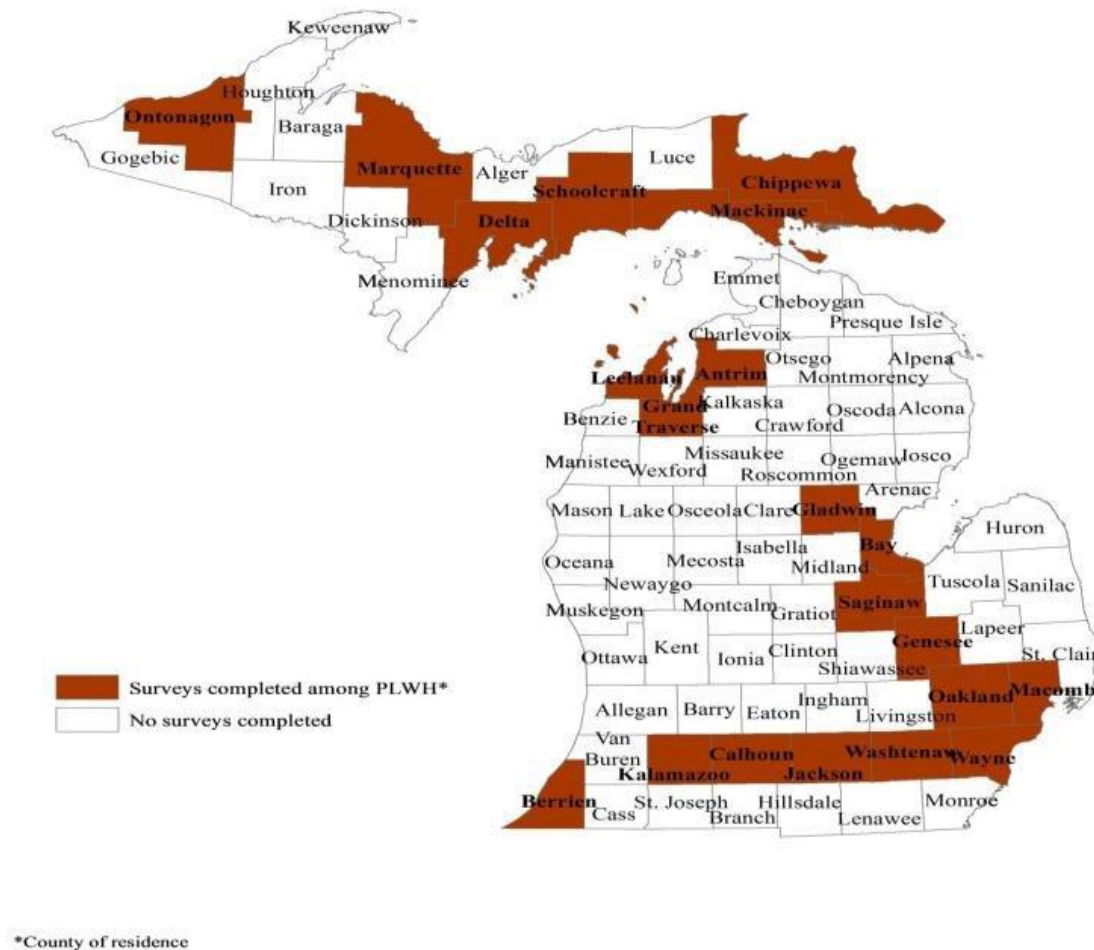


Table 19 presents the demographics of persons living with HIV/AIDS surveyed, including age, gender, race, ethnicity, and sexual identity. Just under half (42%) of those surveyed were between the ages of 18-35, and a vast majority were male (72%). Just over half (51%) of participants were black/African American. Men who have sex with men comprised exactly half of those surveyed throughout the state, followed by those who identified as heterosexual (31%) and bisexual (11%).

Table 19 also presents participants' socio-demographics, including source of income/financial support, type of health insurance, and history of arrest. Salary/wages and Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) were the primary sources of income or financial support among persons living with HIV/AIDS surveyed across the state, at 41% and 37% respectively. 89% of participants reported having Medicaid/Healthy Michigan Plan/Medicare as their form of health insurance, followed distantly by private insurance, at 23%. A significant proportion (40%) of participants reported having been arrested and put in a jail, detention center, or prison for longer than 24 hours.

Table 19: Socio-demographics among persons living with HIV/AIDS, Michigan, 2015

Characteristic	Michigan		Out-State	
	n (n=191)**	%	n (n=76)**	%
Age (years)				
18-25	29	16	4	5
26-35	47	26	11	14
36-45	35	19	14	18
46-55	42	23	32	42
56+	31	17	15	20
Gender				
Male	133	72	51	67
Female	47	25	24	32
Transgender	4	2	1	1
Genderqueer	1	1	0	0
Race				
Black/African American	92	51	31	41
White	70	38	42	55
Multiracial	10	5	1	1
Other^	6	3	1	1
American Indian/Alaska Native	3	2	1	1
Asian	1	1	0	0
Ethnicity				
Not Applicable	118	67	58	76
Other*	30	17	13	17
Hispanic/Latino	12	7	3	4
Unknown	11	6	2	3
Arab/Chaldean	5	3	0	0
Sexual Identity				
Man Who Has Sex with a Man/Gay	92	50	31	41

Heterosexual	58	31	32	42
Bisexual	20	11	8	11
Same Gender Loving	7	4	2	3
Other	7	4	3	4
Queer	3	2	0	0
Woman Who Has Sex with a Woman/Lesbian	1	1	1	1
Income/Financial Support				
Salary/Wages	75	41	12	16
SSI or SSDI	68	37	46	61
Family/Friends	13	7	6	8
Other Public Assistance	7	4	5	7
Pension/Retirement Fund	6	3	3	4
No Income/Financial Support	6	3	3	4
Unemployment Compensation	4	2	0	0
Other^	3	2	1	1
Savings/Investments	1	1	0	0
Type of Insurance*				
Medicaid/Healthy Michigan Plan/Medicare	162	89	56	74
Private	43	23	6	8
Ryan White	23	13	7	9
Other	10	5	6	8
No Health Insurance	4	2	0	0
Veterans Insurance	2	1	1	1
Ever Arrested±				
Yes	74	40	40	53
No	110	60	36	47

**Numbers may not add to total n due to participant nonresponse for certain questions

^ Other race includes those as specified by participants outside of the above choices presented during survey administration

*Other ethnicity includes those as specified by participants outside of the above choices presented during survey administration

^ Other income includes self-employed, sex worker, and student loans

*Categories are not mutually exclusive

±Question reads "Have you ever been arrested and put in a jail, detention center, or prison for longer than 24 hours?"

Table 20 presents unstable housing situations as experienced by persons living with HIV/AIDS surveyed. Roughly a third (32%) of participants reported having experienced an unstable housing situation in the past 12 months. The most common unstable housing situations experienced were living with family/friends in a home the participant did not consider their home (76%), living in a public or private shelter (24%) and living on the street (20%).

Table 20: Unstable Housing among persons living with HIV/AIDS, Michigan, 2015

Characteristic	Michigan		Out-State	
	n (n=191)**	%	n (n=76)**	%
Unstable Housing^				
No	125	68	53	70
Yes	59	32	23	30
Housing Situations*±				
Lived with Family/Friends	45	76	15	65
Lived in Public/Private Shelter	14	24	9	39
Lived on the Street	12	20	4	17
Ever Lacked a Fixed/Regular/Adequate Place to Sleep	11	19	6	26
Lived in Any Other Unstable/Nonpermanent Situation	9	15	4	17
Lived in SRO Hotel	9	15	3	13
Lived in Transitional Housing	6	10	3	13
Lived in an Abandoned Building	6	10	1	4
Lived in a Public Place	4	7	1	4
Lived in a Car	4	7	0	0
Lived in a Jail/Prison/Correctional Facility	3	5	1	4

**Numbers may not add to total n due to participant nonresponse for certain questions

^ Question reads "During the past 12 months, have you experienced any of the following housing situations?"

*Among those who answered "yes" to having experienced any of the listed housing situations

±Categories are not mutually exclusive

3.2.2 HIV TESTING, DIAGNOSIS AND PARTNER SERVICES

A. Testing and Diagnosis

Table 21 presents participants' history of HIV diagnosis, including age at diagnosis, time since diagnosis, setting of positive test and reason for getting tested at that time among survey participants. A combined 64% of those surveyed were between the ages of 18 and 35 when they were diagnosed, with an average age at diagnosis of 29. The majority of participants (56%) were diagnosed with HIV more than 5 years ago. 27% of participants reported having tested positive for HIV in a doctor's office, followed by a health department at 24%. Most PLWH surveyed reported being tested for HIV because they either felt sick or had an illness (31%) or they were concerned after having unprotected sexual contact (28%).

Overall, those surveyed who were diagnosed with HIV within the past year across Michigan tended to be male (68%), were between the ages of 26 and 45 (56%), were black or African American (56%), and identified as either heterosexual (36%) or MSM (36%) (results not displayed in table). Those surveyed who were diagnosed with HIV within the past year in out-state Michigan tended to be female (60%), were between the ages of 36 and 45 (40%), were black or African American (60%), and were heterosexual (80%) (results not displayed in table).

Table 21: History of Diagnosis among persons living with HIV/AIDS, Michigan, 2015

Characteristic	Michigan		Out-State	
	n (n=191)**	%	n (n=76)**	%
Age at HIV Diagnosis (years)				
1-17	15	8	2	3
18-25	56	32	16	22
26-35	56	32	21	29
36-45	35	20	24	33
46-55	14	8	9	12
56+	1	1	1	1
Time Since Diagnosis				
Within the past 3 months	4	2	0	0
3 to 6 months ago	10	6	0	0
6 months to 1 year ago	11	6	5	7
1 to 5 years ago	55	30	17	23
More than 5 years ago	101	56	52	70
Setting of Positive Test				
Doctor's Office	50	27	27	36
Health Department	44	24	13	17
Community HIV/STI Testing Site	32	18	8	11
Emergency Room	25	14	8	11
Other^	14	8	8	11
Prison or Jail	10	5	7	9
Blood Bank/Plasma Center	4	2	2	3
Substance Abuse Treatment Center	2	1	2	3
Home Testing Kit	1	1	0	0
Reason for HIV Test				
Felt Sick or Had an Illness	56	31	28	37
Had Unprotected Sexual Contact	51	28	13	17
Routine HIV Test	31	17	12	16
Other*	25	14	11	15
Health Care Provider Recommended	24	13	9	12
Testing for Other STIs	22	12/	5	7
Notified Partner was Positive	16	9	3	4
Donating Blood	7	4	3	4
Experienced Sexual Assault	6	3	2	3
Was Pregnant	5	3	2	3
Concerned Because Injecting Drugs	4	2	2	3
Required When Entering Prison	4	2	4	5
Required by Military, Court Order, Insurance	3	2	2	3

**Numbers may not add to total n due to participant nonresponse for certain questions

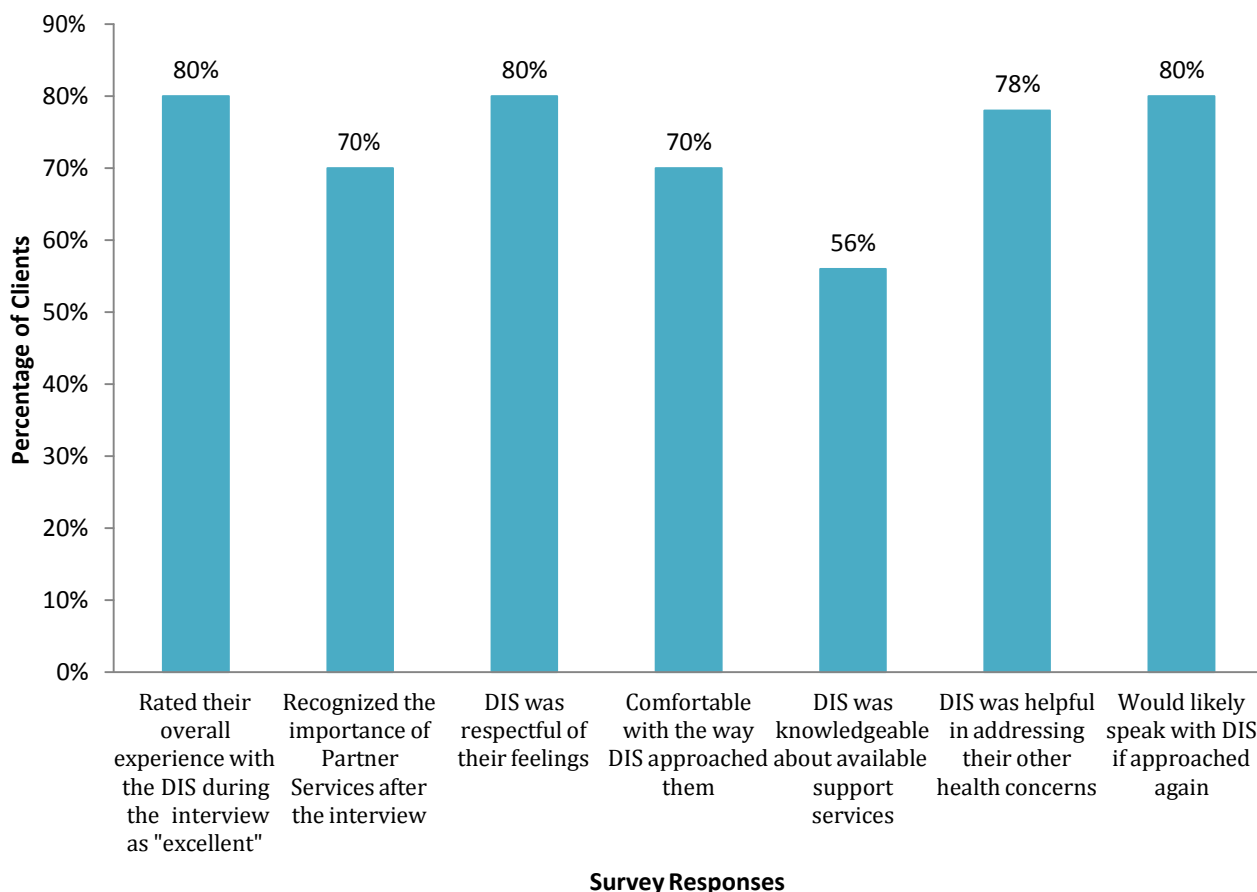
^Other category includes: at college health clinic; Detroit military enlistment processing; free health center; HIV prevention truck; hospital and/or intensive care; in-home life insurance exam; mobile facility; tribal health clinic; and Veteran's hospital.

*Other reasons include: beginning new relationship; fear; partner/former was sick; had other STI; received health coverage; had HIV symptoms; had risky lifestyle; partner asked or were tested together; was performing sex work; required by study; was applying for visa entry to US; and was refused health care unless tested.

B. Partner Services

Less than half (46%) of PLWH surveyed across Michigan stated that they had participated in partner services for HIV or STIs, while in out-state Michigan only 32% stated that they had participated in partner services. Among those who had participated in partner services, 24% reported that their overall experience was “excellent”, while 42% reported that it was “good,”, 14% reported it as “neutral,” 10% reported it as “fair,” and 11% reported it as “poor” (results not shown). Beyond this baseline data, further investigation into the experiences of PLWHA with Partner Services (PS) was not completed due to time constraints. However, to supplement these data are the results of an evaluation of the Disease Intervention Specialist (DIS) interviews for clients with Syphilis completed in May 2015 by MDHHS HIV Prevention staff. Part of this evaluation entailed the distribution of a 13-question client survey to assess the interaction between the client and the DIS as well as the client’s perspective of the original interview with the DIS worker. Although the generalizability of these survey results are limited due to a low client response rate, these results should be used as a basis for future needs assessment research into the perspectives of PLWHA regarding Partner Services. Relevant findings are shown below.

Figure 23: Topics which Clients "Strongly Agreed" upon during Disease Intervention Specialist (DIS) Interviews, Michigan, 2015



While there was little data on the client perspective, DIS were able to share their perspective and thoughts in focus groups and community providers were surveyed regarding their relationship with the DIS. The following reported findings were extracted from a larger evaluation project conducted for the STI Prevention Cooperative Agreement for their Targeted Evaluation Plan. These findings provide more insight into reasons a client may have a negative experience interviewing for Partner Services. These findings are not the direct quotes from the STI Targeted Evaluation Plan; rather, they are the summarized common themes expressed throughout that project. More in depth analysis can be found in the Evaluation report referenced below.

According to the DIS, a contributing factor to a client's poor experience with a PS interview is due to the lack of positive Partner Service messaging. Findings from DIS focus groups found that many DIS expressed that providers (doctors and staff at CBO's) do not explain PS to the client. Furthermore, in a partnership survey, community providers reported from client feedback, that the DIS judged them, they felt PS was a punishment, and felt that they were very much like a number, and not a person. Undoubtedly, further research needs to be conducted to better understand how the perception of clients towards PS can be improved.

3.2.3 MEDICAL CARE

A. Initial Linkage to Medical Care

Table 22 presents the time from positive HIV diagnosis to linkage to medical care as well as ease of seeking medical care after diagnosis by percentage of PLWH surveyed. The majority of participants (72%) were linked to medical care within 3 months of their positive HIV diagnosis. When asked how easy or difficult it was to see a medical professional for HIV medical care after testing positive, less than half (48%) described it as “very easy”.

Table 22: Initial Linkage to Medical Care among persons living with HIV, Michigan, 2015

Characteristic	Michigan		Out-State	
	n (n=191)**	%	n (n=76)**	%
Time from Diagnosis to Linkage to Medical Care				
Less than 3 months after diagnosis	130	72	57	76
3 to 6 months after diagnosis	14	8	5	7
6 months to 1 year after diagnosis	11	6	4	5
More than 1 year after diagnosis	24	13	9	12
I never had HIV medical care	1	1	0	0
Ease of Seeking Medical Care for HIV After Diagnosis				
Very Easy	87	48	46	61
Somewhat Easy	34	19	8	11
Somewhat Difficult	28	16	10	13
Very Difficult	31	17	11	15
**Numbers may not add to total n due to participant nonresponse for certain questions				

Among those participants who responded that seeking medical care after diagnosis was either “somewhat difficult” or “very difficult”, they were asked what made it so. Table 23 presents, in rank order, the top qualitative themes identified among participants regarding what made seeking medical care difficult after diagnosis.

Table 23: Things that made it difficult to seek medical care after diagnosis among persons living with HIV/AIDS, Michigan, 2015

Michigan
1. Had a hard time accepting that diagnosis was real
2. I was scared about being diagnosed with HIV
3. I didn't know where to go for medical care
4. I was embarrassed
Out-State
1. Had a hard time accepting that diagnosis was real
2. I was scared about being diagnosed with HIV
3. I was angry about being diagnosed with HIV
4. Didn't have insurance coverage

Table 24 presents, in rank order, the top qualitative themes identified among all participants regarding the most important things that should be done to make it as easy as possible for someone to get HIV medical care within 3 months of testing positive.

Table 24: Things that ease the immediate receipt of medical care after diagnosis identified among persons living with HIV/AIDS, Michigan, 2015

Michigan

1. At time of diagnosis, provide immediate assistance with scheduling of appointment(s), referral to a local doctor or specialist and access to medication(s)
 2. Provide information to increase knowledge of HIV, along with why it is important to see a doctor immediately, and the available options for medical care and resources
 3. Provide social and emotional support at time of diagnosis, including mental health counseling
 4. Immediate access to case management and community organizations who provide resources for PLWHA
 5. Easy access to insurance and help with medical costs
-

Out-state

1. Provide social and emotional support at time of diagnosis, including mental health counseling
 2. At time of diagnosis, provide immediate assistance with scheduling of appointment(s), referral to a local doctor or specialist and access to medication(s)
 3. Provide information to increase knowledge of HIV, along with why it is important to see a doctor immediately, and the available options for medical care and resources
 4. Provide immediate access to and assistance with insurance and coverage of medical costs
 5. Provide transportation assistance to medical services
-

Those surveyed who were not linked to care within 3 months of diagnosis tended to be older than 46 years of age (46%) and were more likely to have been out of care either 6 months or more or 12 months or more during the past two years (35%) (results not shown). Those surveyed who were not linked to care within 3 months of diagnoses in out-state Michigan also tended to be older than 46 years of age (61%), although fewer reported having been out of care (22%) (results not shown).

B. Current Receipt of Medical Care

The majority (72%) of persons living with HIV/AIDS surveyed across Michigan stated that it is “very easy” to access medical care now, while 28% contend that it either remains only “somewhat easy” (20%), that it is “somewhat difficult” (7%), or that it is “very difficult” (1%) (Table 25).

Table 25: Current Receipt of Medical care among persons living with HIV/AIDS, Michigan, 2015

Characteristic	Michigan		Out-State	
	n (n=191)**	%	n (n=76)**	%
Ease of receiving current medical care				
Very Easy	129	72	59	79
Somewhat Easy	35	20	10	13
Somewhat Difficult	13	7	5	7
Very Difficult	2	1	1	1
**Numbers may not add to total n due to participant nonresponse for certain questions				

Table 26 presents the top qualitative themes regarding what helps participants get medical care now among those who said that current access to medical care for them is “very easy” or “somewhat easy”.

Table 26: Things that help you get medical care now among persons living with HIV/AIDS, Michigan, 2015

Michigan
1. Access to medical insurance and having the ability to pay for care
2. Support and resources from medical care providers and staff
3. Personal responsibility to seek and obtain care
4. Assistance from case manager, counselor, or community organization
Out-State
1. Access to medical insurance and having the ability to pay for care
2. Assistance from case manager, counselor, or community organization
3. Support and resources from medical care providers and staff
4. Personal responsibility to seek and obtain care

Table 27 presents the top qualitative themes regarding what makes it difficult to get medical care now among those who said that current access to medical care for them is “somewhat difficult” or “very difficult”.

Table 27: Things that make it difficult to get medical care now among persons living with HIV/AIDS, Michigan, 2015

Michigan
1. Lack of transportation to medical care
2. Lack of insurance and financial assistance to cover medical care and medication costs
Out-State
1. Lack of insurance and financial assistance to cover medical care and medication costs
2. Lack of transportation to medical care

C. Retention in Care

Table 28 presents care retention data among persons living with HIV/AIDS surveyed. Retention here was defined as seeing a doctor, nurse or other medical case worker for HIV medical care every 6 or 12 months during the past 2 years. Nearly three-quarters of respondents (74%) were retained in care during the past 2 years, while 25% were either out of continuous care (no contact with a doctor, nurse or other medical case worker for 6 months or longer [8%]), or completely out of care (no contact with a doctor, nurse or other medical case worker for 12 months or longer [17%]). Among those who were out of care for either of these periods, the primary reasons given for being out of care were:

- not wanting to think about being HIV positive (50%);
- individual felt fine and didn't think they needed to go for medical care (39%);
- individual forgot or missed their appointment (34%)

Among those who reported having been out of care, 89% reported returning to care. This data does come with a caveat, as survey participants could have reported not having seen a doctor, nurse, or other health care worker for HIV medical care for either 6 months or more or 12 months or more and still could have been prescribed and taking HIV medications.

A higher proportion of respondents who were out of care for 6 months or more were linked to medical care more than 3 months after diagnosis (38% compared with 28% in the general survey population) and experienced an unstable housing situation within the past 12 months (60% compared with 32% in the general survey population). Nearly all (96%) of those out of care had been diagnosed with HIV more than 5 years ago, though only 64% reported being virally suppressed, compared with 73% in the general survey population.

Table 28: Retention in care among persons living with HIV/AIDS, Michigan, 2015

Characteristic	Michigan		Out-State	
	n (n=191)**	%	n (n=76)**	%
Out of Care 6 Months or Longer in Past 2 Years				
Yes	14	8	8	11
No	134	74	61	81
Out of Care 12 Months or Longer in Past 2 Years				
Yes	31	17	6	8
No	149	83	69	92
Combined 6 Months & 12 Months Out of Care				
Yes	45	25	14	19
No	133	74	61	81
Reasons for Not Being In Care^				
Didn't want to think about being HIV positive	22	50	5	36
I felt fine and didn't think I needed to go	17	39	6	43
I forgot or missed my appointment	15	34	3	21
I was unable to get transportation	14	32	3	21
I was homeless or did not have a steady place to live	14	32	5	36
Other*	11	25	6	43
I didn't have enough money or health insurance	11	25	3	21
My CD4 count and viral load are good	11	25	2	14
I had other responsibilities (work, child care)	9	20	2	14
I didn't feel comfortable going there	9	20	3	21
I was drinking or using drugs	8	18	3	21
I was unable to get an appointment	6	14	3	21
I felt too sick to go	6	14	2	14
Stigma related to HIV	5	11	0	0
I didn't like the way I was treated	3	7	1	7
I was incarcerated	3	7	0	0
Clinics/Offices are not private	3	7	3	21
I didn't know where to go	3	7	0	0
My doctor told me I only need to go once a year	2	5	0	0

**Numbers may not add to total n due to participant nonresponse for certain questions

Highlighted numbers signify top four responses in category

^ Categories are not mutually exclusive

*Other reasons include: depression; wasn't contacted about my appointment; didn't feel it was necessary; family issues; forgot to take medication; didn't know I was positive; too long of a drive; have children with health issues and am overwhelmed with appointments; medications were stopped; and was taking care of family member out of state.

Respondents who reported remaining in care for the past 2 years were then asked what helped them stay in care, without stopping or taking a break. Table 29 presents the top qualitative themes elicited from their responses.

Table 29: What helped you stay in care without stopping or taking a break over the past 2 years among persons living with HIV/AIDS, Michigan, 2015

Michigan
1. Personal responsibility to seek care and maintain good health
2. Support from family and friends
3. Fear of becoming ill or health deteriorating
4. Easy access to medical care and medication(s)
Out-State
1. Personal responsibility to seek care and maintain good health
2. Fear of becoming ill or health deteriorating
3. Support from family and friends
4. Easy access to medical care and medication(s)

Those who reported having been out of care but returned to care were asked what most helped them get reconnected with HIV medical care. Table 30 presents the top qualitative themes elicited from their responses.

Table 30: What helped you get reconnected with care after stopping or taking a break, Michigan, 2015

Michigan
1. Sought care through self-initiative
2. Help and motivation from friends and family
3. Received help from case manager, counselor, or community organization
4. Returned to care after becoming ill or fear of becoming ill
5. Received support and encouragement from medical care staff
Out-State
1. Assistance from a case manager, counselor, or community organization
2. Help and motivation from friends and family
3. Sought care through self-initiative
4. Returned to care after becoming ill or fear of becoming ill

All participants were asked what should be done to help someone stay in care without stopping out or taking a break, and the top qualitative themes elicited from their responses are found in table 31.

Table 31: What can be done to help persons living with HIV stay in care without stopping or taking a break, Michigan, 2015

Michigan
1. Having an active support system
2. Provide education on the importance of staying in care
3. Having a case manager who maintains contact with PLWH
4. Having culturally competent doctors, and doctors with good bedside manners
5. Having insurance and coverage for medical services
Out-State
1. Having an active support system
2. Provide education on the importance of staying in care
3. Having a case manager who maintains contact with PLWH
4. Provide transportation assistance to medical care services
5. Having culturally competent doctors, and doctors with good bedside manners

D. Viral Suppression

93% of persons living with HIV surveyed reported having a viral load test within the past year, while 5% reported having a test 1 to 2 years ago, 1% reported having a test 3 to 4 years ago, and 1% reported never having a viral load test. Among those who had a viral load test, 73% had been told they were virally suppressed or had an undetectable viral load; the remaining either had not been told they were virally suppressed/undetectable (19%) or were unsure (8%).

3.2.4 INITIAL LINKAGE TO CASE MANAGER

The majority (75%) of PLWH surveyed reported ever having used a case manager since their HIV diagnosis. 57% of participants stated that they were initially linked with a case manager within 3 months of their diagnosis, compared to 13% who were linked 3 to 6 months after diagnosis, 4% between 6 months to 1 year, and 25% more than 1 year after being diagnosed with HIV (Table 32).

Table 32: Initial linkage to a case manager among persons living with HIV/AIDS, Michigan, 2015

Characteristic	Michigan		Out-State	
	n (n=191)**	%	n (n=76)**	%
Ever used a case manager	135	75	62	83
Time from Diagnosis to Linkage to case manager				
Less than 3 months after diagnosis	77	57	34	56
3 to 6 months after diagnosis	18	13	6	10
6 months to 1 year after diagnosis	5	4	3	5
More than 1 year after diagnosis	34	25	18	30
I never had a case manager	46	25	13	17

**Numbers may not add to total n due to participant nonresponse for certain questions

Table 33 presents the top qualitative themes elicited among all participants regarding the most important things that should be done to make it as easy as possible for someone to get connected to a case manager within three months of testing positive.

Table 33: Things that ease initial linkage to a case manager within three months after diagnosis among persons living with HIV/AIDS, Michigan, 2015

Michigan
1. Have HIV medical care options explained at the time of testing and a list of local organizations that can provide case management services
2. Have open and honest communication at time of diagnosis, specifically to address any mental health concerns and provide social support
3. Immediately link or refer at time of diagnosis to a case manager or organization that provides these services
Out-State
1. Have HIV medical care options explained at the time of testing and a list of local organizations that can provide case management services
2. Immediately link or refer at time of diagnosis to a case manager or organization that provides these services
3. Have a list of resources, including contact information, and information readily available

3.2.5 HIV Medications

Nearly all (94%) of persons living with HIV surveyed reported currently taking HIV medications, although 40% reported having skipped or missed a dose of their medication during the past 30 days (Table 34). When asked how easy or difficult it was to take their HIV medications without skipping or missing any doses, 59% stated it was “very easy”, 26% stated it was “somewhat easy”, 10% stated it was “somewhat difficult”, and 5% stated it was “very difficult”.

Table 34. Current medication use among persons living with HIV/AIDS, Michigan, 2015

Characteristic	Michigan		Out-State	
	n (n=191)	%	n (n=76)	%
Currently prescribed HIV medications				
Yes	171	94	75	100
No	11	6	0	0
Skipped/missed dose of HIV medication in past 30 days				
Yes	69	40	22	29
No	102	60	53	71
Ease of taking HIV medications without skipping/missing dose				
Very easy	101	59	54	72
Somewhat easy	44	26	15	20
Somewhat difficult	17	10	4	5
Very difficult	8	5	2	3

Table 35 presents the top qualitative themes elicited among participant responses regarding those things identified as helping participants take their HIV medications without skipping or missing a dose.

Table 35: What helps you take HIV medications without skipping or missing a dose among persons living with HIV/AIDS, Michigan, 2015

Michigan	
1. Making taking the medications a part of my routine or habit	
2. Desire to maintain good health	
3. Setting alarms and daily reminders	
4. Medication is sorted into daily pill boxes/sorters	
Out-State	
1. Making taking the medications a part of my routine or habit	
2. Medication is sorted into daily pill boxes/sorters	
3. Desire to maintain good health	
4. Motivation and encouragement from family and friends	

3.2.6 MANAGING INFECTION & CHALLENGES EXPERIENCED

When asked to rate themselves on the management of their HIV infection, the majority of respondents reported managing their infection well (79%), followed by those who manage it okay (16%), those who manage it poorly (2%), those who do not manage it at all (1%), and those who were unsure (2%).

Participants also reported the challenges they had experienced since becoming diagnosed with HIV, with the most common challenge being “telling friends/family about my HIV status” (37%); the most common challenges experienced by those living in out-state Michigan were “paying copays for prescription drugs” (48%) and “maintaining stable housing” (48%). Table 36 presents the challenges experienced among PLWH surveyed.

Table 36: Challenges experienced since testing positive among persons living with HIV/AIDS, Michigan 2015

Characteristic	Michigan		Out-State	
	n (n=191)**	%	n (n=76)**	%
Challenges[^]				
Telling friends/family about HIV status	67	37	28	41
Meeting people I can relate to	65	36	30	43
Paying copays for prescription drugs	60	33	33	48
Telling sex partners about HIV status	59	33	21	30
Maintaining stable housing (rent, mortgage, etc.)	58	32	33	48
Feeling trapped, damned, or doomed	57	31	29	42
Paying medical bills	56	31	30	43
Meeting other HIV positive people	55	30	27	39
Feeling confident I won't infect others	50	28	23	33
Finding employment or staying employed	49	27	28	41
Maintaining insurance coverage	50	28	15	22
Getting to doctor's appointments or other services	45	25	19	28
Practicing safer sex	38	21	13	19
Talking about healthy relationships	32	18	15	22
Abusing alcohol/drugs	30	17	13	19
Having access to food or feeding my family	30	17	17	25
Finding an HIV doctor near me	22	12	10	14
Other*	19	10	15	22
Having access to condoms	18	10	11	16
Finding support for my children	4	2	0	0
Accessing clean/sterile needles/works	1	1	1	1

**Numbers may not add to total n due to participant nonresponse for certain questions

Highlighted numbers signify top four responses in category

[^] Categories are not mutually exclusive

*Other challenges include: anxiety, stress, depression and mental health; finding accepting partner; feeling dirty; getting SSI/SSDI; health problems; difficulty finding love; domestic violence; pain and pain management; stigma; and wanting to have children.

3.2.7 SUPPORT SERVICES AND PROGRAMS

Table 37 presents the support services that persons living with HIV/AIDS reported needing in the past 12 months. The majority of respondents reported needing dental care (55%). It should be noted that these responses may include services participants have needed and have not received, as well as have needed and have received.

Table 37: Support services needed during past year among persons living with HIV/AIDS, Michigan 2015

Characteristic	Michigan		Out-State	
	n (n=191)**	%	n (n=76)**	%
Services Needed^				
Dental care	99	55	46	62
HIV case management services	87	48	46	62
Mental health services	78	43	30	41
Transportation assistance	73	41	41	55
Medicine through ADAP	67	37	31	42
Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI)	66	37	41	55
Meal or food services	65	36	36	49
HIV peer group support	64	36	24	32
HIV prevention counseling	44	24	17	23
Shelter or housing services	44	24	23	31
Insurance enrollment assistance	34	19	17	23
Nutritional services	30	17	8	11
Professional help remembering to take HIV medicines	22	12	9	12
Drug or alcohol counseling/treatment	22	12	9	12
Home health services	16	9	11	15
Other*	12	7	9	12
Childcare services	5	3	1	1
Domestic violence services	1	1	1	1
Interpreter services	1	1	0	0

**Numbers may not add to total n due to participant nonresponse for certain questions

Highlighted numbers signify top four responses in category

^ Categories are not mutually exclusive

*Other services include: care for hepatitis C; chiropractic services; assistance paying bills and other housing assistance; hormones; legal services; spiritual support; and other insurance assistance.

A. HIV Programs & Information

Respondents were asked about previous participation and interest in participating in individual, group, or linkage prevention programs (Table 38). Approximately 70% of respondents participated in any program, with the most popular program being “Healthy Relationships” (24%).

Table 38: Program use & interest among persons living with HIV/AIDS, Michigan, 2015

Characteristic	Michigan		Out-State	
	n (n=191)**	%	n (n=76)**	%
Programs Utilized by Participants^				
None	51	29	28	41
Group program: “Healthy Relationships” (HIV+ men & women)	42	24	18	26
Linkage program: “Antiretroviral Treatment and Access to Services” (ARTAS) (HIV+ men & women)	13	8	6	9
Group program: “Mpowerment” (Young MSM at risk)	19	11	6	9
Individual program: “Individual Level HIV Risk Reduction Counseling” (ILRRC) (HIV+ men & women))	17	10	10	15
Group program: “Prevention Options for Positives” (POP) (HIV+ MSM)	24	14	11	16
I don’t know	36	21	5	7
Other similar programs*	38	22	15	22
Interest in Group/Individual Interventions				
Am interested	134	75	53	73
Am not interested	45	25	20	27
**Numbers may not add to total n due to participant nonresponse for certain questions				
Highlighted numbers signify top four responses in category				
^Categories are not mutually exclusive				
*Other similar programs include: Brothers Saving Brothers (BSB); Camps for HIV positive persons; EIS; general support groups at community based organizations; HELP; Lighthouse; Life Skills; Moms in Motion; Sista; smoking cessation groups; TEAMS; and unspecified women’s support groups.				

Participants were also asked which topics, if any, they would be most interested in learning about. Approximately 80% of respondents stated that they would like to learn more about one or more of the topics presented in the survey. Of those who stated that they wanted to learn more about a topic, the majority wanted to learn more about stress reduction (73%) (Table 39).

Table 39: Topics of interest among persons living with HIV/AIDS, Michigan, 2015

Characteristic	Michigan		Out-State	
	n (n=191)**	%	n (n=76)**	%
Topics^				
Stress Reduction	105	73	43	74
Feeling better about myself and my HIV status	85	59	35	60
Disclosing my HIV status to a sexual partner	53	37	16	28
Disclosing my HIV status to family/friends	51	35	19	33
Talking to my partner about healthy relationships	51	35	21	36
How to reduce the spread of HIV and STIs	51	35	19	33
Skill building on medication adherence	43	30	20	34
How to access medical care and support services	42	29	22	38
How to practice safer sex	37	26	17	29
Maintaining a monogamous relationship	37	26	15	26
How to avoid alcohol use	29	20	14	24
How to avoid drug use	28	19	13	22
How to use condoms or dental dams	17	12	8	14
Other*	16	11	12	21
Reducing my number of sexual partners	15	10	5	9

**Numbers may not add to total n due to participant nonresponse for certain questions

Highlighted numbers signify top four responses in category

^Categories are not mutually exclusive

*Other topics include: accessing DHS network for health insurance and food stamps; anger management; becoming a peer supporter; greater involvement in churches; having children while HIV positive; pursuing legal repercussions for status disclosure without permission; how to deal with HIV while dealing with other medical issues; information on PrEP; smoking cessation; and weight management.

3.2.8 PREP KNOWLEDGE AND ATTITUDES

Table 40 presents participants' knowledge and attitudes regarding pre-exposure prophylaxis, or PrEP. The majority of respondents had either heard of an HIV prevention pill or had heard specifically about PrEP (68%), although only 38% knew anyone who was currently using PrEP. Nearly all would encourage an at-risk friend to take PrEP (93%) and three quarters knew where to get PrEP (75%).

Table 40: PrEP knowledge & attitudes among persons living with HIV/AIDS, Michigan 2015

Characteristic	Michigan		Out-State	
	n (n=191)**	%	n (n=76)**	%
Heard of Prevention Pill or PrEP				
Yes	122	68	40	54
No	57	32	34	46
Know Anyone on PrEP				
Yes	46	38	7	18
No	76	62	33	83
Encourage At-Risk Friend to Take PrEP				
I would	113	93	34	85
I would not	9	7	6	15
Know Where to Get PrEP				
Yes	92	75	34	85
No	30	25	6	15
**Numbers may not add to total n due to participant nonresponse for certain questions				

3.2.9 IMPROVING HIV SERVICES

Table 41 describes participant responses when asked “which of the following should HIV care providers do to serve you better”; over half stated “know what HIV related services are in my area and refer me to them” (65%) and “be more experienced/knowledgeable about providing HIV care” (54%).

Table 41: Ways that providers can better serve persons living with HIV/AIDS, Michigan, 2015

Characteristic	Michigan		Out-State	
	n (n=191)**	%	n (n=76)**	%
Ways to Better Serve PLWH				
Know HIV services in area/provide referrals	104	65	43	59
More experience/knowledge regarding HIV care	87	54	33	45
Advocate for client needs within service system	78	48	34	47
Greater LGBTQ sensitivity and experience	64	40	22	30
More convenient office hours	59	37	15	21
Provide services in more convenient location	59	37	21	29
Reduce appointment wait times	56	35	16	22
Make appointments quicker	55	34	19	26
Greater cultural sensitivity and experience	53	33	21	29
Know a language other than English	39	24	16	22
Other*	20	12	7	10

**Numbers may not add to total n due to participant nonresponse for certain questions

^Categories are not mutually exclusive

*Other category includes: after hours phone service with providers; ability to see only one doctor or keep one infectious doctor; promptly respond to phone calls or messages; be better informed; be more client oriented and spend more time with clients; be more confidential; improved bedside manner; streamline services; and nothing could be done to improve services.

Participants were also asked what most important change they would suggest to improve services for individuals or families living with HIV, and the top qualitative themes elicited from their responses are provided in table 42.

Table 42: Most important change to improve services for persons living with HIV/AIDS, Michigan, 2015

Michigan
1. No suggestions for improvement – the current system works
2. Increase support groups and mental health support
3. Increase access to medical care and community resources
4. Expand HIV care education
Out-State
1. No suggestions for improvement – the current system works
2. Increase support groups and mental health support
3. Increase access to helpful community resources
4. Have service and medical providers who care about the population, are respectful, and are confidential

SECTION 3.2 SUMMARY: SURVEY OF PERSONS LIVING WITH HIV/AIDS IN MICHIGAN

- A total of 191 surveys were administered with participants representing 21 Michigan counties. 56% of participants were from the DMA; 40% were from Out-State Michigan.
- This survey is not representative of the state of Michigan and does not include clients from the west side of the state. Data from this survey should be used in addition to other secondary data sources.
- Just under half of participants were between the ages of 18-35, the majority were male and half were black/African American.
- Half identified as MSM, while 31% were heterosexual and 11% were bisexual.
- Salary/wages were the primary forms of financial support for participants, followed by Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI)
- Most were on Medicaid, Medicare, or the Healthy Michigan Plan.
- A third of participants had an unstable housing situation in the past 12 months.
- 40% had been arrested and put in a jail, detention center, or prison for longer than 24 hours.
- 64% of participants were between the ages of 18 and 35 when they were diagnosed with HIV; most tested positive in either a doctor's office or at a health department, and most were tested because they either felt sick or they were concerned after having unprotected sexual contact.
- Those diagnosed within the past year tended to be male, were between the ages of 26 and 45, were black/African American, and identified as either MSM or heterosexual.
- Most were linked to HIV medical care within 3 months of diagnosis; those not linked to medical care within 3 months tended to be older than 46 years of age and were more likely to have been out of care during the past 2 years.
- Most participants had used a case manager since being diagnosed with HIV, though just over half were linked to a case manager within 3 months of their diagnosis.
- 25% of participants were out of care for either 6 months or longer or 12 months or longer in the past 2 years; most were out of care because they didn't want to think about being HIV positive or they felt fine and didn't think they needed to be in care.
- Those who were out of care were more likely to have linked to medical care more than 3 months after their diagnosis and were more likely to have experienced an unstable housing situation in the past 12 months.

3.3. PRIMARY DATA COLLECTION AMONG SURVEY PARTICIPANTS AT-RISK FOR HIV/AIDS IN MICHIGAN

As the second part of the Themes and Strengths portion of the MAPP assessment (see Section 1.1 Needs Assessment Process), a statewide, in-person survey was conducted among persons at risk for HIV/AIDS. The purpose of this survey was to supplement and address gaps in existing secondary data within the state. An original survey, consisting primarily of multiple choice questions, was developed by MPHI with feedback and input from the Themes and Strengths and Steering Committees. Survey topics included history of HIV testing, participation in risky behaviors, HIV/STI prevention education, partner services, prevention of HIV, and knowledge and attitudes regarding pre-exposure prophylaxis (PrEP). However, because survey data were not a random sampling of the population, data does not represent the population as a whole and cannot be generalizable. A copy of the survey tool can be found in the Appendix.

Participants were recruited with the assistance of local health departments, HIV/AIDS service organizations (ASOs), community based organizations (CBOs), HIV/AIDS prevention support groups, testing facilities, bars and social settings as referred by members of the Steering Committee and Subcommittees. Organizations were asked to target recruitment efforts to persons at risk for HIV from specific groups (e.g., young black men who have sex with men, transgender individuals, injecting drug users, high risk heterosexuals, etc.). Several organizations and support groups were chosen as recruitment locations because their primary client population represented one of our targeted groups. The personal risk of persons who participated in this survey was not assessed, rather, this was a convenience sample based on those persons without HIV who were willing to participate at each of the recruitment locations. Surveys were administered in a private location by trained interviewers, or self-administered if a participant preferred to do so. The consent process and administration of the survey took anywhere from 30 to 40 minutes to complete and respondents were provided a \$20 Visa gift card for their time. Data from multiple choice questions were analyzed using the Statistical Package for the Social Sciences (SPSS) and are presented using descriptive statistics. Surveys were not audio-recorded, thus all answers to open-ended questions consisted of notes written by interviewers or participants with few verbatim, direct quotes. Data from open ended questions were coded and organized into themes. Responses under each theme were enumerated and themes were presented in rank order.

The research protocol, informed consent script, and survey tool were approved by the Institutional Review Board (IRB) at the Michigan Public Health Institute in Okemos, Michigan and the Michigan Department of Health and Human Services IRB in Lansing, Michigan.

3.3.1 DEMOGRAPHICS

Trained survey administrators traveled to recruitment sites throughout the state, administering a total of 51 surveys to individuals at-risk for HIV. The vast majority of these surveys (80%) were administered in Wayne, Oakland and Macomb counties within the Detroit Metropolitan Statistical Area (DMA, comprised of Wayne, Oakland, Lapeer, Macomb, Monroe and St. Clair counties) while 9 (18%) were administered in out-state Michigan (comprised of all counties excluding those within the DMA); the remaining 1 survey was missing data on location as the participant chose not to provide information on

Table 43 presents demographics among the persons at-risk for HIV surveyed, including age, gender, race, ethnicity, and sexual identity. Half of those surveyed were between the ages of 18 and 25 years, 70% were male, and just over half were black/African American (52%). 38% of participants identified as men who have sex with men, followed by 26% who identified as heterosexual.

Figure 24: County of residence among persons at risk for HIV infection surveyed, Michigan, 2015



*County of residence

Table 43: Demographics among persons at-risk for HIV/AIDS, Michigan, 2015

Characteristic	Michigan	
	n (n=51)**	%
Age (years)		
18-25	25	50
26-35	17	34
36+	8	16
Gender		
Male	35	70
Female	10	20
Transgender	4	8
Genderqueer	1	2
Race		
Black/African American	26	52
White	13	26
Multiracial	9	18
Asian	1	2
Other^	1	2
Ethnicity		
Not Applicable	35	71
Unknown	5	10
Other*	4	8
Hispanic/Latino	2	4
Arab/Chaldean	3	6
Sexual Identity		
Man Who Has Sex with a Man/Gay	19	38
Heterosexual	13	26
Bisexual	9	18
Same Gender Loving	5	10
Queer	4	8
**Numbers may not add to total n due to participant nonresponse for certain questions		
^Other race includes American Indian/Alaska Native		
*Other ethnicity includes Black Puerto Rican (n=1), Indian and Black (n=1), Serbian (n=1), and did not specify (n=1).		

Table 44 presents participants' socio-demographics, including source of income/financial support, type of health insurance, and history of arrest. Salary/wages were the primary sources of income or financial support among persons at-risk surveyed (68%). Just over half of participants reported having private insurance (51%), followed by Medicaid/Healthy Michigan Plan/Medicare (43%). 27% of participants reported ever having been arrested and put in a jail, detention center, or prison for longer than 24 hours.

Table 44: Socio-Demographics among persons at-risk for HIV/AIDS, Michigan, 2015

Characteristic	Michigan	
	n (n=51)**	%
Income/Financial Support^		
Salary/Wages	34	68
SSI or SSDI	6	12
Family/Friends	6	12
Other*	4	8
Unemployment Compensation	3	6
Savings/Investments	2	4
No Income/Financial Support	1	2
Other Public Assistance	1	2
Pension/Retirement Fund	0	0
Type of Insurance		
Private	25	51
Medicaid/Healthy Michigan Plan/Medicare	21	43
No Health Insurance	3	6
Veterans Insurance	1	2
Ever Arrested±		
Yes	13	27
No	36	73

**Numbers may not add to total n due to participant nonresponse for certain questions

^ Categories are not mutually exclusive

*Other income includes settlement (n=1), small business owner (n=1) and student loans (n=1)

±Question reads "Have you ever been arrested and put in a jail, detention center, or prison for longer than 24 hours?"

Table 45 presents unstable housing situations as experienced by persons at-risk surveyed. Over a third of participants reported having experienced an unstable housing situation in the past 12 months (36%). The most common unstable housing situation experienced was living with family/friends in a home the participant did not consider their home (78%).

Table 45: Unstable housing among persons at-risk for HIV/AIDS, Michigan, 2015

Characteristic	Michigan	
	n (n=51)**	%
Unstable Housing[^]		
No	32	64
Yes	18	36
Housing Situations*[±]		
Lived with Family/Friends	14	78
Lived in Any Other Unstable/Nonpermanent Situation	7	39
Lived on the Street	3	17
Lived in Public/Private Shelter	3	17
Lived in Transitional Housing	3	17
Lived in a Car	3	17
Lived in a Jail/Prison/Correctional Facility	2	11
Ever Lacked a Fixed/Regular/Adequate Place to Sleep	2	11
Lived in SRO Hotel	2	11
Lived in an Abandoned Building	2	11
Lived in a Public Place	1	6
**Numbers may not add to total n due to participant nonresponse for certain questions		
[^] Question reads “During the past 12 months, have you experienced any of the following housing situations?”		
*Among those who answered “yes” to having experienced any of the listed housing situations		
[±] Categories are not mutually exclusive		

3.3.2 HIV TESTING

Table 46 presents participants' history of HIV testing, including ever been tested for HIV, time since most recent HIV test, setting of most recent HIV test, and reason for getting most recent HIV test. Nearly all persons at-risk surveyed reported having had an HIV test (96%), though it should be noted that participants were primarily recruited from community organizations and health departments in which HIV testing occurs. Eighty four percent of participants had an HIV test within the past year, and over half had been tested most recently at community HIV/STI testing site (58%). The majority of participants were tested because they were concerned after having unprotected sexual contact (60%) or they were receiving a routine HIV test (42%).

Table 46: History of testing among persons at-risk for HIV/AIDS, Michigan, 2015

Characteristic	Michigan	
	n (n=51)**	%
Ever Tested for HIV		
Yes	43	96
No	2	4
Time Since Most Recent HIV Test		
Within the past year	36	84
1 to 2 years ago	2	5
3 to 4 years ago	3	7
More than 5 years ago	2	5
Setting of Most Recent HIV Test		
Community HIV/STI Testing Site	25	58
Doctor's Office	9	21
Other^	3	7
Health Department	4	9
Emergency Room	1	2
Prison or Jail	1	2
Reason for HIV Test		
Concerned about unprotected sexual contact	26	60
Getting routine HIV test	18	42
Tested for other STIs	11	26
Other*	6	14
Health care provider recommended I get tested	4	9
Notified partner was HIV positive	2	5
Needle stick follow up or occupational exposure	2	5
Experienced sexual assault	2	5
I was pregnant	1	2
Injected drugs with a needle	0	0
Felt sick or had an illness	0	0

**Numbers may not add to total n due to participant nonresponse for certain questions

^Other setting of HIV test includes club (n=1), Detroit Job Corps (n=1) and Menjo's Night Club (n=1).

*Other reasons for HIV test include asking for PrEP prescription (n=1), getting a check-up/routine physical (n=2), was concerned after risky behaviors (n=1), was required by prison (n=1), and was getting married (n=1).

3.3.3 MEDICAL CARE

Participants were asked if they had gone to the doctor in the past year for a non-emergency visit and if so, whether their health care provider had offered them an HIV test. 70% of those surveyed reported having seen a doctor, though only 38% of those were offered an HIV test.

3.3.4 HEALTH BEHAVIORS

Most (80%) respondents reported having had unprotected sex with a non-monogamous partner. Table 47 presents risky behaviors engaged in by participants; the most common risky behavior was oral sex (mouth-penis) (83%), followed by insertive anal sex without a condom (71%).

Table 47: Health behaviors among persons at-risk for HIV/AIDS, Michigan, 2015

Characteristic	Michigan	
	n (n=51)**	%
Risky Behavior		
Oral sex (mouth-penis)	40	83
Insertive anal sex without a condom	34	71
Insertive anal sex with a condom	27	56
Oral sex (mouth-anus/rimming)	26	54
Receptive anal sex without a condom	24	50
Receptive anal sex with a condom	23	48
Vaginal sex without a condom	21	44
Vaginal sex with a condom	17	35
Oral sex (mouth-vagina)	16	33
Injecting drugs that were not prescribed to be by physician	2	4
Sharing needles for drug use	1	2
Sharing other works for injecting drug use	0	0
Blood transfusion/receipt of blood products	0	0
I don't know	0	0
Other	0	0
**Numbers may not add to total n due to participant nonresponse for certain questions		

3.3.5 HIV/STI PREVENTION EDUCATION

The majority of persons at-risk who were surveyed reported having received HIV/STI prevention education (90%), and over half had received this education from a community based organization (57%). Table 48 presents HIV/STI prevention education data from persons at-risk who participated in the survey.

Table 48: HIV prevention education among persons at-risk for HIV/AIDS, Michigan, 2015

Characteristic	Michigan	
	n (n=51)**	%
Received HIV/STI Prevention Education		
Yes	44	90
No	5	10
Setting of HIV/STI Prevention Education^		
Community based organization	25	57
School	15	34
Medical setting	13	30
Other*	5	11
**Numbers may not add to total n due to participant nonresponse for certain questions		
^Categories were not mutually exclusive		
*Other setting includes gay club/bar (n=1), HIV positive friends (n=1), Horizons (n=1), Michigan Dept. of Corrections (n=1),		

Participants were also asked which topics, if any, they would be most interested in learning more about; topics included stress reduction, avoiding drug and alcohol use, and practicing safe sex, among others. Table 49 presents participants responses regarding learning further about these topics. Among the 90% interested in learning more, most were interested in learning more about stress reduction (52%), followed by skill building on how to reduce the spread of HIV/STIs (38%).

Table 49: Topics of interest among persons at-risk for HIV/AIDS, Michigan, 2015

Characteristic	Michigan	
	n (n=51)**	%
Topics^		
Stress reduction	25	58
Skill building to reduce spread of HIV/STIs	18	38
Maintaining a monogamous relationship	17	35
How to talk to partner(s) about HIV/STIs	16	33
Accessing medical care and support services	14	29
Reducing number of sexual partners	13	27
How to avoid drug use	8	17
How to use condoms or dental dams	7	15
How to avoid alcohol use	5	10
Other*	2	4
**Numbers may not add to total n due to participant nonresponse for certain questions		
^Categories are not mutually exclusive		
*Other topics include PrEP (n=1) and why certain populations of gay community are more at risk (n=1)		

3.3.6 PARTNER SERVICES

Forty-one percent of persons at-risk for HIV had heard of partner services for people with HIV/STIs. 30% had reported participating in HIV/STI partner services at some point. Of those who reported participating in partner services, 33% described their experience as “excellent”, 17% described their experience as “neutral” and 17% described their experience as “poor”. Refer to section 3.2.2 for more information on the experiences of clients with Partner Services.

3.3.7 HIV PREVENTION

In an open-ended question, participants were asked what they think is the most important thing someone can do to keep from getting HIV; the top qualitative themes elicited from participant responses is presented in table 50.

Table 50: Most important thing to prevent HIV infection among at-risk persons, Michigan, 2015

Michigan
1. Practice safe sex (i.e., use a condom)
2. Abstain from sex
3. Talk with sex partner(s) about HIV status
4. Limit number of sex partners
5. Get tested

A. PrEP Knowledge and Attitudes

Table 51 presents participants' knowledge and attitudes regarding pre-exposure prophylaxis, or PrEP. Over half of persons at-risk surveyed had either heard of a pill to prevent HIV or had heard specifically about PrEP (59%), and 57% knew of someplace they could go to get PrEP. 84% of participants would consider taking PrEP if they and their doctor felt it was right for them and 88% would encourage an at-risk friend to take PrEP. Only 29% of participants knew someone currently using PrEP.

Table 51: PrEP knowledge & attitudes among persons at-risk for HIV/AIDS, Michigan, 2015

Characteristic	Michigan	
	n (n=51)**	%
Heard of Pill to Prevent HIV or PrEP		
Yes	29	59
No	20	41
Feel Comfortable Discussing PrEP with Doctor		
Yes	42	86
No	7	14
Would Consider Taking PrEP		
Yes	41	84
No	8	16
Why Wouldn't You Consider Taking PrEP^		
I don't think it is right for me	5	71
I worry about side effects	4	57
It is too expensive	2	29
Other*	2	29
I don't think it works	1	14
Someone might find out I am taking it	1	14
I am not at risk for HIV	1	14
I don't think it's safe	1	14
Encourage At-Risk Friend to Take PrEP		
I would	43	88
I would not	6	12
Know Anyone On PrEP		
Yes	14	29
No	35	71
Trust PrEP to Protect You from HIV		
Yes	34	71
No	14	29
Know Where to Get PrEP		
Yes	28	57
No	18	37

**Numbers may not add to total n due to participant nonresponse for certain questions

^Among those who said they would not consider taking PrEP

*Other reasons include 'I worry about taking medications like this' (n=1) and 'I prefer condoms' (n=1)

SECTION 3.3 SUMMARY: SURVEY OF PERSONS AT-RISK FOR HIV/AIDS IN MICHIGAN

- A total of 51 surveys were administered with persons at-risk for HIV representing 5 counties in Michigan. 80% of participants were from the DMA; 18% were from Out-State Michigan.
- This survey is not representative of the state of Michigan and does not include respondents from the west side of the state. Data from this survey should be used in addition to other secondary data sources.
- Half of participants were between the ages of 18 and 25 years, the majority of respondents were male, and just over half were black/African American.
- 38% identified as MSM, 26% identified as heterosexual, and 18% were bisexual
- Salary/wages were the primary forms of financial support for participants.
- Just over half of participants had private insurance, 43% were on Medicaid, Medicare, or the Healthy Michigan Plan.
- Just over a third of participants had experienced an unstable housing situation in the past 12 months.
- Nearly all had received an HIV test, most within the past year. Most were tested at a community HIV/STI testing site.
- The majority were tested because they were concerned after having unprotected sexual contact or they were receiving a routine HIV test.
- While 70% reported having been to a doctor in the past year for a non-emergency visit, only 38% were offered an HIV test.
- 80% of participants reported having had unprotected sexual contact with a non-monogamous partner; the most common risky behaviors engaged in by participants were oral sex (mouth-penis) and insertive anal sex without a condom.
- Most had received HIV/STI prevention education and over half received this education from a community based organization.
- Participants were most interested in learning about stress reduction, skill building on how to reduce the spread of HIV/STIs, and how to maintain a monogamous relationship.
- Over half of participants had heard either heard of an HIV prevention pill or had specifically heard about PrEP; most felt comfortable discussing PrEP with their doctor and most would consider taking PrEP if they and their doctor felt it was right for them.
- Among those who would not consider taking PrEP, the top reasons included not thinking PrEP was right for them, worrying about the side effects, and feeling that PrEP is too expensive.

3.4. COMMUNITY ENGAGEMENT AND SEXUAL HEALTH SURVEYS

Throughout the needs assessment process, several community surveys were circulated by members of the steering committee. The below community engagement and sexual health survey was conducted by Michigan HIV/AIDS Council community members among various populations at-risk for HIV infection. Interviews were conducted at ten different sites in six cities in Michigan and include Detroit, Ann Arbor, Jackson, Flint, Kalamazoo, and Grand Rapids (Table 52).

Table 52: Interview Sites for Community Engagement and Sexual Health Survey

Event	Description	Location
Necto Night Club	A dance club that has offered Pride Night since 1984	Ann Arbor
Hotter Than July Event	Multi-day pride celebration for Black LGBT persons	Detroit
HIV Awareness Event Pleasant Grove Baptist Church	A free event offered as part of National Women & Girls HIV/AIDS Awareness Day	Detroit
Institute for Population Health	Health Center	Detroit
Motor City Pride Festival	Largest gathering of LGBTQ community in Michigan	Detroit
Walgreens on E. Jefferson	Public location	Detroit
Jackson Peace Prom	A prom for LGBT students	Jackson
Flint Pride Event	Gathering of LGBT community in Flint	Flint
Kalamazoo Pride Event	Gathering of LGBT community in Kalamazoo	Kalamazoo
The Network- Grand Rapids	An LGBT organization in Grand Rapids	Grand Rapids

Survey questions focused on the respondents' own personal concern for HIV infection, frequency in which HIV/STIs were discussed with family, friends, and medical professionals, whether the respondent had ever been tested for HIV, whether information on safer sex had ever been received, and of knowledge about Pre-exposure prophylaxis (PrEP). Information collected from these surveys provides insight concerning issues related to HIV prevention and offers understandings into the opinions of the community. However, because survey data were not a random sampling of the population, data does not represent the population as a whole and cannot be generalizable.

A total of 397 individuals residing in several counties in Michigan (Wayne, Oakland, Macomb, Saginaw, Eaton, Lapeer, Washtenaw, Ingham, Genesee, Marquette, Kent, Muskegon, Ottawa, Allegan, Ionia, Sanilac, Montcalm, Newaygo) completed a survey. Table 53 presents the demographic characteristics of the survey participants. Overall, participants had a mean age of 30 years with a range of 12 to 74 years. The majority of respondents were female (48%), with 40% being male, 11% transgender, and less than 1% identifying as gender non-conforming. More than half of the respondents were White (51%), 36% Black/African-American, 4% were Multi-racial, 4% Hispanic/Spanish, 3% Asian/Pacific Islander, 2% Other and less than 1% Native American. Most respondents identified as gay (32%) or straight (31%), with 15% identifying as bisexual, 9% identifying as lesbian, 8% identifying as pansexual, and 5% identifying as queer.

Table 53: Characteristics of community engagement survey participants, Michigan 2015

	N	%
Gender		
Male	160	40
Female	193	48
Transgender	44	11
Gender Non-conforming	1	<1
Total^	399	
Race/Ethnicity		
White	193	51
Black/African American	137	36
Multi-racial	15	4
Latino/Spanish Origins	14	4
Asian/Pacific Islander^	10	3
Other	9	2
Native American	2	<1
Total^	380	
Gender Identity		
Gay	100	33
Straight	93	31
Bisexual	45	15
Lesbian	27	9
Pansexual	25	8
Queer	14	5
Total	304	
Age (years)		
Mean	30	
Range	12 to 74 years	
^Categories were not mutually exclusive		

Respondents were asked whether HIV and other sexually transmitted infections (STIs) were a concern for them and then asked a follow up question as to why or why not (Table 54). More than half of the respondents (67%) said that HIV/STIs were not a concern. Respondents indicated that HIV/STIs were not a concern because they were not currently sexually active (60%) or because they were in a committed relationship (28%). Most respondents who were concerned about HIV/STIs were concerned because they were currently sexually active (67%) and because they had trust issues within their relationship (23%).

Table 54: HIV/STIs as a concern among community engagement survey participants, Michigan 2015

	N	%
Is HIV/STIs a concern for you?		
Yes	111	33
No	221	67
Total	332	
Why are HIV/STIs a concern for you?^		
I have trust issues within my relationship	26	23
I have been and/or am sexually active	75	67
Other	11	10
Total^	112	
Why are HIV/STIs not a concern for you?^		
I am not sexually active at this time	67	60
I am in a committed relationship and/or married	40	35
Other	6	5
Total	113	
^Categories are not mutually exclusive		

Most respondents indicated that they have talked ‘some’ with both their family (45%) and friends (42%) about HIV/STIs (Table 56). Twenty-two percent and 32% of respondents said that talked ‘often’ with family and friends, respectively. Half of survey respondents (50%) had talked with a health care provider about HIV/STIs, 45% have not talked about HIV/STIs with a health care provider and 5% indicated having a discussion on HIV/STIs with a health care did not apply to them.

Table 55: Discussion of HIV/STIs among community engagement survey participants, Michigan 2015

	N	%
Discuss HIV/STIs with Family		
Never	132	33
Some	178	45
Often	86	22
Total	396	
Discuss HIV/STIs with Friends		
Never	102	26
Some	164	42
Often	126	32
Other	3	<1
Total	395	
Discussed HIV/STIs with Health Care Provider		
Yes	161	50
No	145	45
Not Applicable	17	5
Total	323	

Table 56 presents HIV testing among survey participants. The majority of survey respondents had been tested for HIV (64%). The most common reason for being tested was 'I just want to know my status'. Other reasons for being tested were 'I have sex without a condom', 'I started a new relationship', and 'my partner asked me to get tested'. Reasons for not being tested for HIV include 'I don't feel as though I am at risk for HIV', 'I don't know where to get tested', and 'I am afraid of finding out my HIV status'. Thirty-six percent of survey respondents indicated not having a partner, 35% said that their partner had been tested for HIV, 16% said that their partner had not been tested for HIV, and 13% did not know whether their partner had been tested for HIV or not. Over 60% of respondents said that a health care provider had never recommended they get an HIV test.

Table 56: HIV testing among community engagement survey participants, Michigan 2015

	N	%
Have you ever been tested for HIV?		
Yes	214	64
No	121	36
Total	335	
Why were you tested for HIV?		
I just wanted to know my status	75	55
I have had sex without a condom	23	17
I started a new relationship	18	13
My partner asked me to get tested	4	3
Other	17	12
Total	137	
Why were for never tested for HIV?		
I don't feel as though I am at risk for HIV	16	59
I don't know where to get tested	3	11
I am afraid of finding out my HIV status	1	4
Other	7	26
Total	27	
Has your partner been tested for HIV?		
Yes	136	35
No	63	16
I don't know	52	13
I don't have a partner	142	36
Total	393	
Has a health care provider suggested you get tested for HIV?		
Yes	111	28
No	266	68
Not Applicable	14	4
Total	391	

Most respondents said that they did receive some type of information on safer sex from their parents/guardians (61%) and from school (64%) (Table 57). The majority of respondents (56%) feel favorable to receiving HIV information in church and 10% would not like to receive HIV information in church.

Table 57: Information on safer sex and HIV among community engagement survey participants, Michigan 2015

	N	%
Received safer sex information from parent/guardian		
Yes	239	61
No	151	38
Total	393	
Received safer sex information from school		
Yes	247	64
No	116	31
Total	385	
How would you feel about receiving HIV information in church?		
I would be okay with it	219	56
I would not be okay with it	37	10
I don't go to a place of worship	128	33
Other	5	1
Total	389	

Over half of the respondents (63%) had not heard of PrEP (Table 58). Of those who had heard of PrEP, 23% said they knew ‘a lot’, 28% said they knew ‘some’, and 30% said they knew ‘a little’. Most respondents (82%) did not know where to get PrEP. Approximately 31% said they would consider using PrEP, 10% would not consider using PrEP, and 41% were not sure if they would use PrEP or not.

Table 58: Knowledge of PrEP among community engagement survey participants, Michigan 2015

	N	%
Have you ever heard of PrEP?		
Yes	133	37
No	231	63
Total	364	
How much do you know about PrEP?		
A lot	33	23
Some	41	28
A Little	43	30
Other	28	19
Total	145	
Do you know where to get PrEP?		
Yes	49	18
No	218	82
Total	267	
Would you consider using PrEP?		
Yes	88	31
No	28	10
Not Applicable	53	18
Not Sure	117	41
Total	286	

Most of respondents (68%) indicated that there were no barriers to accessing HIV prevention treatment in their community (Table 59). Of those that indicated that there were barriers, 28% said that not knowing where to go for services was the biggest barrier. Other common barriers included not having health insurance, not having local services available, lack of transportation, and feeling judged by providers.

Table 59: Barriers to HIV prevention and treatment among community engagement survey participants, Michigan 2015

	N	%
Do you believe there are barriers to receiving HIV prevention and treatment services in your community?		
Yes	94	28
No	228	68
Don't know/Not sure	14	4
Total	336	
What are the barriers?		
I don't know where to go	17	28
I don't have health insurance	11	18
No services exist in my neighborhood	11	18
No transportation	9	15
Providers will judge me	8	13
It takes too much time	2	4
Other	2	4
Total	60	

SECTION 3.4 SUMMARY: COMMUNITY ENGAGEMENT SURVEYS

- The Community Engagement and Sexual Health Survey was completed with 397 individuals at-risk for HIV infection at ten different sites in Detroit, Ann Arbor, Jackson, Flint, Kalamazoo and Grand Rapids.
- Most (48%) of respondents identified as female, with 40% identifying as male, 11% as transgender and less than 1% as gender non-conforming.
- Most respondents (51%) identified as White, with 36% identifying as White, 4% as Multi-racial, 4% as Latino/Spanish Origins, 3% Asian/Pacific Islander, 2% Other and less than 1% as Native American.
- Most respondents identified as gay (32%) or straight (31%), with 15% identifying as bisexual, 9% identifying as lesbian, 8% identifying as pansexual, and 5% identifying as queer.
- The mean age of respondents was 30 years with a range of 12 to 74 years.
- More than half of respondents (67%) indicated that HIV/STIs were not a concern, with most (60%) indicating it wasn't a concern due to not being sexually active at this time.
- 33% of respondents indicated that HIV/STIs were a concern for them, with most (67%) being concerned because they were currently sexually active.
- Most respondents indicated they have discussed HIV/STIs some with both family (45%) and friends (42%).
- Half (50%) indicated they have discussed HIV/STIs with their health care provider. 68% indicated that their health care provider has not suggested them getting tested for HIV.
- Most respondents (64%) have been tested for HIV, with 55% indicating their reason for being tested was wanting to know their status.
- Most respondents that have not been tested (36%) indicated their reason for not being tested was not feeling as though they are at risk for HIV (59%).
- Most (36%) respondents indicated not having a partner or indicated their partners have been tested for HIV (35%).
- Most respondents indicated they have received safer sex information from their parent/guardian (61%) and their school (64%).
- Most respondents (56%) indicated they would be okay with receiving HIV information in church.
- Most respondents (63%) had not heard of PrEP. Of those that had heard of PrEP, 30% indicated that they only knew a little about it. Most respondents (82%) did not know where they could get PrEP. Most respondents indicated they would consider using PrEP (31%) or weren't sure if they would consider using PrEP (41%).
- Most respondents (68%) indicated they did not believe there were barriers to receiving HIV prevention and treatment services in their community. Of the 30% that did indicate there were barriers, 28% indicated that the most common barrier experienced was not knowing where to go for services.

SECTION 4: PROVIDER SURVEYS IN MICHIGAN

4.1 PRIMARY DATA COLLECTION AMONG PROFESSIONALS PROVIDING CARE AND SERVICES TO PERSONS LIVING WITH HIV/AIDS IN MICHIGAN

As part of the health systems assessment (see Section 1.1 Needs Assessment Process) we surveyed professionals throughout Michigan who provide care or services to persons living with HIV (PLWH) to gain a better understanding of how medical and service providers counsel or treat patients and of the barriers experienced while providing care or services to PLWH. Of particular interest to the HIV Planning Steering Committee was how the Affordable Care Act and Medicaid expansion impacted care and service delivery for PLWH in Michigan. This was the first time that Michigan conducted a provider survey as part of the needs assessment process.

The survey was self-administered and respondents had the option to respond to an online version via Survey Monkey or a hard copy that was mailed to the provider office. The survey consisted of mostly multiple choice questions and took approximately 30 minutes to complete. Providers were not given an incentive for their time. Survey questions were reviewed by the HIV Planning Steering Committee for readability, consistency with survey goals, and for content. Survey topics included: provider demographics, provider comfort discussing HIV transmission and care, services routinely offered to patients or clients with HIV, how providers link PLWH to medical and support services, provider confidence in medical, dental, and support services offered to PLWH, antiretroviral medications that prevent HIV transmission, barriers to providing care or services, patient experiences, and current education needs. However, because survey data were not a random sampling of the population, data does not represent the population as a whole and cannot be generalizable. A copy of the survey tool can be found in the Appendix.

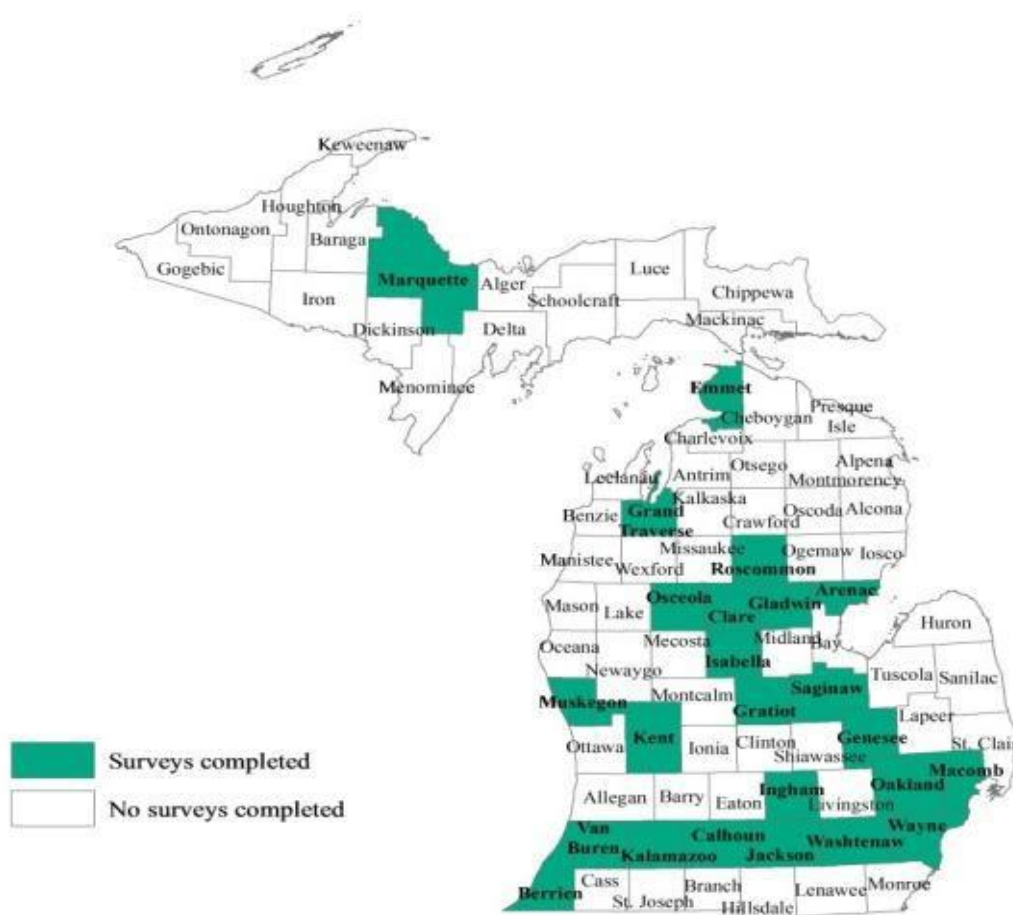
The research protocol, informed consent script, and survey tool were approved by the Institutional Review Board (IRB) at the Michigan Public Health Institute in Okemos, Michigan. Data from closed ended questions were analyzed using the Statistical Package for the Social Sciences (SPSS) and are presented using descriptive statistics.

A. Survey Respondents

A total of 159 professionals who provide care or services to PLWH throughout Michigan completed a survey. Of these, 57 (36%) provided care or services in the Detroit Metropolitan Area (DMA), which is comprised of Wayne, Oakland, Lapeer, Macomb, Monroe, and St. Clair counties. Eighty-one professionals (51%) provided care or services in out-state Michigan, which is comprised of all counties in Michigan excluding those in the DMA. In this section, data will be presented for all of Michigan, which includes the DMA and Out State, and Out State only. Data from the DMA region of Michigan are presented in Section 7 of this document.

Figure 25 displays the counties in Michigan in which survey respondents provided care and services to persons living with HIV. Wayne County consisted of the most respondents (33%), followed by the counties of Oakland (9%), Kalamazoo (9%), Berrien (7%), Saginaw (7%), Ingham (6%), Muskegon (5%), Washtenaw (5%), Genesee (4%), and Kent (4%). Approximately 1% of professionals indicated that they worked throughout all counties in Michigan and 1% indicated specific regions in Michigan where they worked.

Figure 25: County of employment among medical professional and service providers surveyed, Michigan 2015



4.1.1 INDIVIDUAL AND ORGANIZATIONAL DEMOGRAPHICS

Table 60 presents professional characteristics of the survey respondents. In Michigan, nearly half of the survey respondents were nurses, nurse practitioners, or advanced practice nurses (48%), followed by case managers (14%), social workers (11%), health educators (9%), administrators and program directors (9%), and physicians/physician assistants (8%). The majority of professionals had worked in their field for 11 years or more (63%). Approximately 15% of professionals had worked for 6 to 10 years and 16% of professionals had worked in their field for 1 to 5 years. Five percent of respondents had worked in their field for less than 1 year. Twenty-three percent of professionals worked in a health department, 21% of professionals worked in a community-based organization (CBO), 17% of professionals worked in HIV clinical specialty care, 10% worked in a federally qualified health center or community health center (FQHC/CHC), and 9% worked in a hospital setting. Approximately 19% of professionals worked in other types of organizations which included pharmacies, correctional facilities, urgent cares, solo practices, domestic abuse shelters, sexual assault examiner programs, school-based clinics, and community mental health practices.

Table 60: Professional demographics among surveyed providers surveyed, Michigan, 2015

Characteristic	Michigan		Out-State	
	n	%	n	%
Total	159	100	81	51
Profession[^]				
Nurse/NP/APRN	71	48	39	48
Case Manager	21	14	14	17
Social Worker	16	11	7	9
Health Educator	13	9	6	7
Administrator/Program Director/Manager	13	9	6	7
Physician/Physician Assistant	12	8	5	6
Clinical Pharmacist	7	5	3	4
Other*	7	5	3	4
Dentist/Dental Hygienist	6	4	4	5
Mental Health Provider	5	3	1	1
Experience				
Less than 1 year	8	5	6	8
1-5 years	24	16	13	16
6-10 years	22	15	13	16
11+ years	92	63	48	60
Organization Type				
Health Department	32	23	26	33
CBO	29	21	16	20
Other	26	19	11	14
HIV clinical specialty care	23	17	13	16
FQHC/HC	14	10	10	13
Hospital	13	9	4	5
[^] Categories were not mutually exclusive				
*Other profession includes dental hygienist (n=1), director of client services (n=1), intervention specialist (n=1), executive director (n=1), medical case manager (n=1), MPH (n=1), pharmacist (n=1), prevention specialist (n=1), program manager (n=1), and care and counseling (n=1)				
Nurse/NP/APRN = Nurse/Nurse Practitioner/Advanced Practice Nurse; CBO = Community-based organization; FQHC/CHC = Federally Qualified Health Center/Community Health Center				

Table 61 presents the individual demographic characteristics of the survey respondents. Three-fourths of the survey respondents were women, 23% were men, and 1% was transgender. The majority of professionals were White (73%), 20% were Black, 4% were Asian, and 3% were multi-racial. Five percent of survey respondents were Hispanic/Latino and 2% were Arab/Chaldean. The majority of professionals identified themselves as heterosexual (81%). Nine percent of professionals self-identified as men who had sex with men, 4% of respondents self-identified as Queer, 3% self-identified as women who have sex with women, and 2% self-identified as bisexual.

Table 61: Individual demographics among surveyed providers, Michigan, 2015

Characteristic	Michigan		Out-State	
	n	%	n	%
Total	159**	100	81**	51
Gender				
Male	34	23	21	26
Female	111	76	59	74
Transgender	1	1	0	0
Race[^]				
White	107	73	65	81
Black/African American	29	20	9	11
Asian	6	4	3	4
Multiracial	4	3	3	4
American Indian/Alaska Native	0	0	0	0
Other	2	1	2	3
Ethnicity				
Hispanic/Latino	7	5	4	5
Arab/Chaldean	2	2	0	0
None of the above	125	94	71	96
Sexual Identity				
Heterosexual/Straight	112	81	58	77
MSM/Gay	12	9	5	7
Queer	5	4	2	3
WSW/Lesbian	4	3	4	5
Bisexual	3	2	3	4
Other	3	2	3	4

**Numbers may not add to total n due to participant nonresponse for certain questions

[^]Categories were not mutually exclusive

In Michigan, the median number of clients with HIV infection that professionals provided care or services for in the past 5 days was 20, with a range of 0 to 200 (Table 62). The median number of clients with HIV infection seen in the past five days in Out State Michigan was 29, with a range of 1 to 150 patients. Approximately 40% of professionals had more than 50% of their client population consisting of PLWH and 40% of professionals had less than 10% of their client population consisting of PLWH.

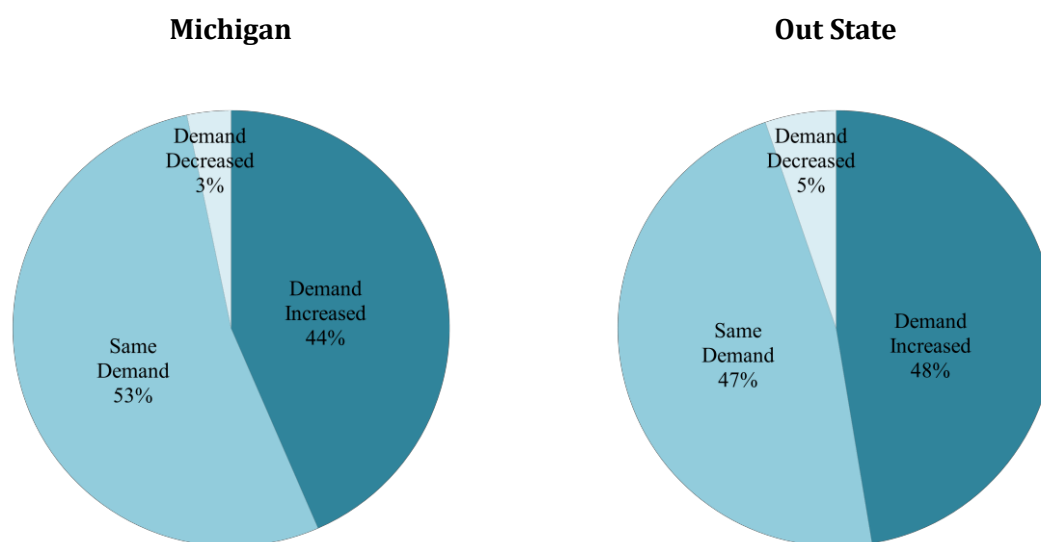
Table 62: Clients with HIV Infection, Michigan, 2015

	Michigan		Out-State	
	n	%	n	%
Proportion of Clients who are HIV+				
Less than 10%	52	40	30	41
11-25%	14	11	5	7
26-50%	11	9	7	9
More than 50%	52	40	32	43
Number of Clients with HIV Receiving care/Services in Past 5 Days				
Mean	31		29	
Median	20		20	
Range	0 to 200		0 to 150	

4.1.2 IMPACT OF THE AFFORDABLE CARE ACT AND MEDICAID EXPANSION IN MICHIGAN

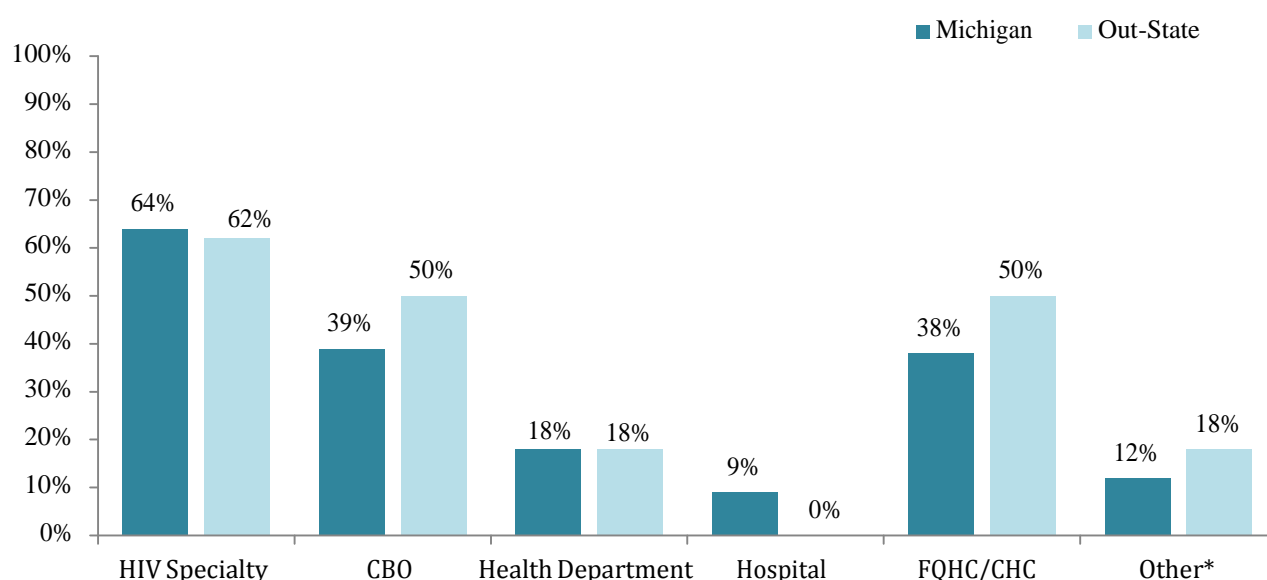
When asked how the demand for services has changed among persons living with HIV since the implementation of the Healthy Michigan Plan and Medicaid expansion, 44% of professionals said that demand increased, 53% of professionals said that the demand stayed the same, and 3% of professionals said the demand decreased (Figure 26).

Figure 26: Demand for Services since the implementation of the Healthy Michigan Plan/Medicaid Expansion, Michigan, 2015



Each organization represented by medical and service provider participants was classified into one of the following categories by members of the Steering Committee: ‘HIV clinical specialty care organizations’; ‘CBO’; ‘health department’; ‘hospital’; ‘FQHC/CHC’; and ‘other’. Please see the footnote below Figure 23 for further explication regarding those organizations classified in the ‘other’ category. A greater percentage of professionals representing HIV clinical specialty care organizations (64%) experienced an increase in demand for services compared to other organization types. In Michigan, 39% of professionals representing CBOs and 38% of professionals representing FQHC/CHCs experienced an increased demand in services. In out-state Michigan, 50% of professionals representing CBOs and 50% of professionals representing FQHC/CHCs experienced an increase in demand for services (Figure 27).

Figure 27: Experienced an increase in demand for services since the implementation of the Healthy Michigan Plan/Medicaid Expansion by organization type, Michigan, 2015



*Other includes urgent care (n=1), department of corrections (n=4), physician practice group (n=3), specialty pharmacy (n=2), specialty pharmacy (n=2), sexual assault examiners (n=2), home care agency (n=1), tribal clinic (n=1), community mental health center (n=1), behavioral health services center (n=1), research center (n=1), solo practice (n=1), general practice (n=1); school-based clinic (n=1), medical school (n=1).

Approximately 42% of professionals in Michigan and 45% of professionals in Out State have experienced burdens due to the implementation of the Affordable Care Act and Medicaid Expansion (Table 63). Of these, a greater percentage of professionals working in HIV clinical specialty care have experienced burdens compared to professionals from other organization types in Michigan (57%) and Out State (62%). In Michigan, 56% of professionals representing hospitals, 44% of professionals representing health departments, and 43% of professionals representing CBOs reported experiencing burdens. In Out State, 56% of professionals representing CBOs and 43% of professionals representing health departments reported experiencing burdens.

Table 63: Experienced burdens due to the implementation of the Affordable Care Act or Medicaid Expansion, Michigan, 2015

	Yes, Experienced Burdens	Total orgs	
	n	n	%
Michigan			
HIV Specialty	12	21	57
CBO	12	28	43
Health Department	12	27	44
Hospital	5	9	56
FQHC/CHC	3	13	23
Other*	7	24	29
Total	51	122	42
Out State			
HIV Specialty	8	13	62
CBO	9	16	56
Health Department	9	21	43
Hospital	0	2	0
FQHC/CHC	3	10	30
Other*	4	11	36
Total	33	73	45
CBO = Community-based organization; FQHC/CHC = Federally Qualified Health Center/Community Health Center			
* Other includes urgent care (n=1), department of corrections (n=4), physician practice group (n=3), specialty pharmacy (n=2), specialty pharmacy (n=2), sexual assault examiners (n=2), home care agency (n=1), tribal clinic (n=1), community mental health center (n=1), behavioral health services center (n=1), research center (n=1), solo practice (n=1), general practice (n=1), school-based clinic (n=1), medical school (n=1).			

A follow up question to those who experienced burdens was to describe the burdens experienced due to the implementation of the Affordable Care Act and Medicaid expansion. The most frequent theme identified related to having an increased workload. Many respondents said that the increased workload was due to an increased patient/client volume and also due to an increase in the amount of time to assist patients/clients in getting health coverage. Having clients unexpectedly lose insurance or experience lapses in coverage was identified as another burden. In Out State, the responses related more to self-employed clients or clients that were seasonal or temporary employees losing coverage or having lapses in coverage. The responses in the DMA related more to loss of coverage due to system errors, one example being that the Insurance Assistance Program (IAP) failed to pay for a client's coverage resulting in termination of insurance. Cost was found to be a burden experienced by professionals in that costs to provide services to clients were greater than reimbursement rates. Also, the cost of deductibles, copays, and medications were too high for some clients which respondents felt deterred patients from accessing care. Some professionals spoke of the infrastructure in itself being too complicated and frustrating. Client churn as clients moved from "eligible to ineligible" for Medicaid,

AIDS Drug Assistance Programs (ADAP) failure to pay ACA premiums, lack of communication from MDHHS, as well as problems with the ACA website were all issues that were noted as problematic. Having the capacity to accommodate the increased volume of patients was mentioned by a few respondents as a burden experienced. One burden that was identified in Out State but not in the DMA was that some professionals found it challenging to find providers that accepted patients' health plans. Table 64 presents, in rank order, the top themes identified among participant responses regarding the burdens they have experienced since the Affordable Care Act and Medicaid expansion.

Table 64: Description of burdens experienced due to the implementation of the Affordable Care Act or Medicaid Expansion, Michigan, 2015

1. There is an increased workload due to increased patient/client volume and increased complexity to accessing insurance
2. Patients/clients are losing their insurance coverage unexpectedly/lapses in coverage
3. Cost - high deductibles/copays and low reimbursement rates
4. Infrastructure can be frustrating/confusing
5. Challenge finding providers for clients
6. Not having the capacity to accommodate increased volume

4.1.3 COMFORT WITH SERVICE PROVISION

A. Discussing HIV Transmission

One hundred seventeen respondents (74%) indicated that they did discuss topics related to HIV transmission with their patient/clients. Of these, the majority of professionals were 'very comfortable' discussing HIV transmission with a vast majority of population groups in Michigan and Out State (Table 65). Fewer professionals reported feeling 'very comfortable' discussing HIV transmission with persons with limited English proficiency and children ages 0 to 12 years. Table 66 and Table 67 display comfort discussing HIV transmission by organization type in Michigan and Out State, respectively. Comfort discussing HIV transmission varied by organization type and population group and no single organization type consistently fared better than another. However, more professionals representing HIV clinical specialty care and Health Departments were 'very comfortable' discussing HIV transmission compared to professionals from other organization types. Professionals with less experience in their field were slightly less comfortable discussing HIV transmission than professionals with more experience (Figure 28).

Table 65: Professionals ‘very comfortable’ discussing HIV transmission with client population groups, Michigan, 2015

	Michigan		Out-State	
	n	%	n	%
Persons Living with HIV	103	92	62	93
Men Who Have Sex with Men	103	93	61	92
Substance User/Chemical Dependents	88	79	49	73
Medicaid Eligible	96	88	57	89
Racial/Ethnic Minorities	104	92	63	94
Men	106	95	64	96
Women	101	91	60	91
Adolescents (13-19 years)	88	85	52	83
Children (0-12 years)	37	49	24	51
Transgender	86	77	53	79
Sex Workers	93	85	54	82
Persons with Limited English Proficiency	41	39	24	36
Professionals who indicated that they did not interact with a population were excluded from the analysis				

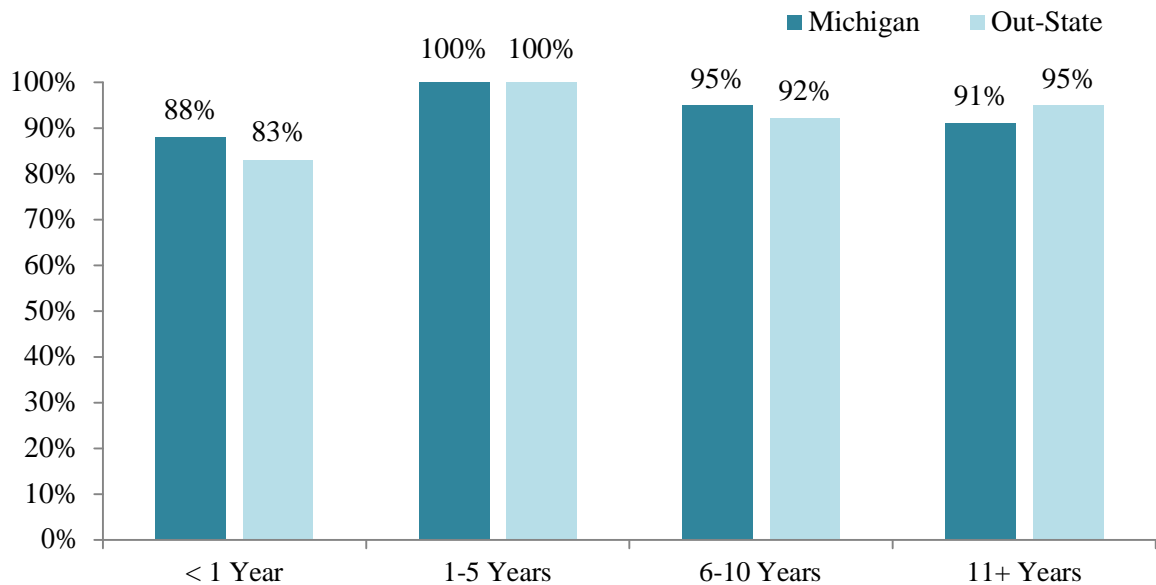
Table 66: Professionals ‘very comfortable’ discussing HIV transmission with client populations by organization type, Michigan Only, 2015

	HIV Specialty	CBO	Health Dept.	Hospital	FQHC/C HC	Other
	%	%	%	%	%	%
Persons Living with HIV	100	96	100	86	82	82
Men Who Have Sex with Men	100	100	96	86	82	88
Substance User/Chemical Dependents	86	69	89	100	64	78
Medicaid Eligible	91	92	89	86	90	88
Racial/Ethnic Minorities	95	92	100	86	91	89
Men	100	100	100	100	91	88
Women	100	85	96	100	82	94
Adolescents (13-19 years)	95	79	96	71	70	93
Children (0-12 years)	56	45	50	100	40	50
Transgender	82	84	74	83	73	78
Sex Workers	90	81	93	83	73	89
Persons with Limited English Proficiency	36	58	41	50	20	24
Professionals who indicated that they did not interact with a population were excluded from the analysis						

Table 67: Professionals ‘very comfortable’ discussing HIV transmission with client populations by organization type, Out State Only, 2015

	HIV Specialty %	CBO %	Health Dept. %	Hospital %	FQHC/C HC %	Other %
Persons Living with HIV	100	100	100	100	89	57
Men Who Have Sex with Men	100	100	95	100	89	67
Substance User/Chemical Dependents	77	64	86	100	67	57
Medicaid Eligible	100	86	86	100	100	80
Racial/Ethnic Minorities	100	93	100	100	100	71
Men	100	100	100	100	100	71
Women	100	86	95	100	89	83
Adolescents (13-19 years)	91	71	95	50	78	83
Children (0-12 years)	63	43	57	--	40	60
Transgender	85	86	76	100	78	71
Sex Workers	85	71	90	100	78	71
Persons with Limited English Proficiency	38	43	38	50	25	29
Professionals who indicated that they did not interact with a population were excluded from the analysis						

Figure 28: Professionals ‘very comfortable’ discussing HIV transmission with client populations by experience, Michigan, 2015



B. Discussing HIV Care

One hundred twelve respondents (70%) indicated that they did discuss topics related to HIV care with their patient/clients. Of these, the majority of professionals were ‘very comfortable’ discussing HIV care with a vast majority of population groups in Michigan and Out State (Table 69). However, overall, fewer professionals were ‘very comfortable’ discussing topics related to HIV care compared to HIV transmission. Similar to discussing HIV transmission, the population groups that had the least number of professionals ‘very comfortable’ discussing HIV care were persons with limited English proficiency and children ages 0 to 12 years (Table 68). Table 69 and Table 70 display comfort discussing HIV care by organization type in Michigan and Out State, respectively. Comfort discussing HIV care varied by organization type and population group, however, more professionals representing HIV clinical specialty care were ‘very comfortable’ discussing HIV care compared to professionals representing other organization types. Unlike discussing HIV transmission, professionals with less experience in their field were slightly more comfortable discussing HIV care compared to professionals with more experience (Figure 29).

Table 68: Professionals ‘very comfortable’ discussing HIV care with client population groups, Michigan, 2015

	Michigan		Out-State	
	n	%	n	%
Persons Living with HIV	97	87	58	88
Men Who Have Sex with Men	96	87	57	86
Substance User/Chemical Dependents	93	84	53	80
Medicaid Eligible	91	84	54	86
Racial/Ethnic Minorities	97	87	57	86
Men	98	89	59	89
Women	96	87	56	86
Adolescents (13-19 years)	78	77	48	76
Children (0-12 years)	36	52	25	57
Transgender	86	78	52	79
Persons with Limited English Proficiency	51	48	31	48
Professionals who indicated that they did not interact with a population were excluded from the analysis				

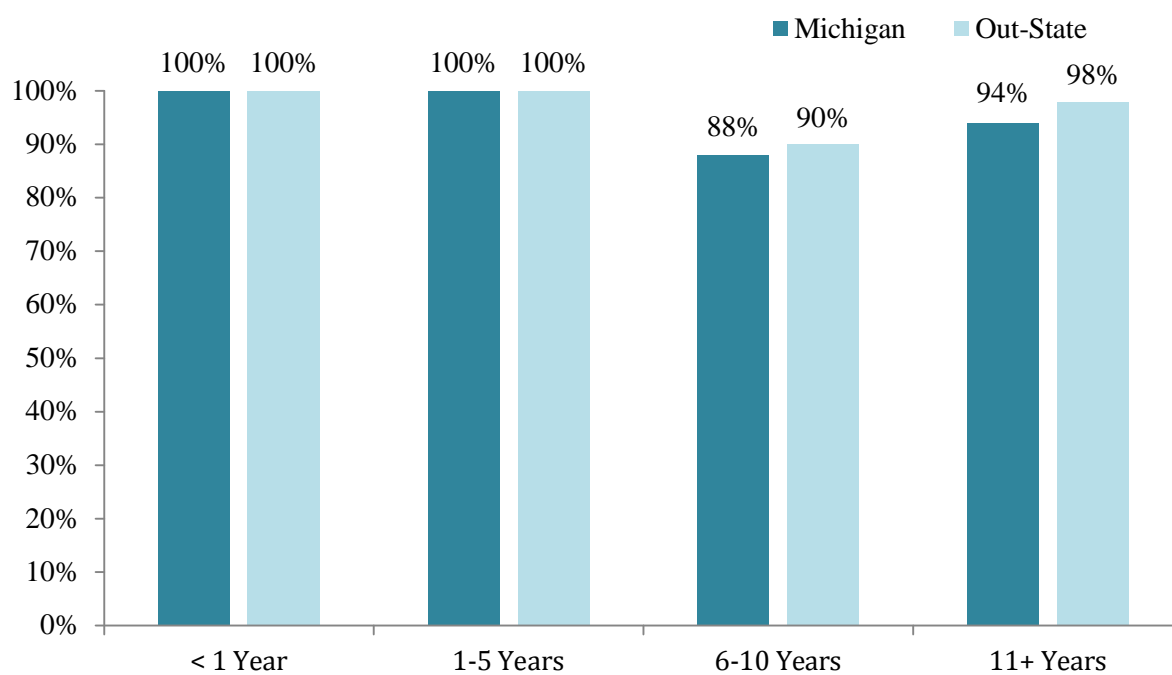
Table 69: Professionals ‘very comfortable’ discussing HIV care with client populations by organization type, Michigan Only, 2015

	HIV Specialty %	CBO %	Health Dept. %	Hospital %	FQHC/C HC %	Other %
Persons Living with HIV	100	92	92	100	82	74
Men Who Have Sex with Men	100	96	88	100	73	78
Substance User/Chemical Dependents	95	88	85	100	73	79
Medicaid Eligible	95	88	88	100	70	76
Racial/Ethnic Minorities	100	92	92	100	73	79
Men	100	96	92	100	82	78
Women	100	88	88	100	82	83
Adolescents (13-19 years)	95	68	88	67	60	75
Children (0-12 years)	71	39	53	--	60	54
Transgender	91	88	81	83	73	61
Persons with Limited English Proficiency	55	67	52	50	36	24
Professionals who indicated that they did not interact with a population were excluded from the analysis						

Table 70: Professionals ‘very comfortable’ discussing HIV care with client populations by organization type, Out State Only, 2015

	HIV Specialty %	CBO %	Health Dept. %	Hospital %	FQHC/C HC %	Other %
Persons Living with HIV	100	92	90	100	89	63
Men Who Have Sex with Men	100	100	85	100	78	63
Substance User/Chemical Dependents	92	85	80	100	78	63
Medicaid Eligible	100	85	85	100	88	67
Racial/Ethnic Minorities	100	92	90	100	78	63
Men	100	100	90	100	89	63
Women	100	85	85	100	89	71
Adolescents (13-19 years)	91	69	85	50	67	71
Children (0-12 years)	86	46	58	--	60	50
Transgender	92	85	85	50	78	50
Persons with Limited English Proficiency	54	54	53	50	44	29
Professionals who indicated that they did not interact with a population were excluded from the analysis						

Figure 29: Professionals ‘very comfortable’ discussing HIV care with client populations by experience, Michigan, 2015



C. Providing Medical Care to Persons Living with HIV

Professionals were very confident in the provision of most services offered to PLWH, but not all (Table 71). Only half of professionals surveyed were ‘very confident’ in providing dental screening and care to PLWH and only 38% of professionals were ‘very confident’ in treating chronic hepatitis. Slightly more than half of professionals were ‘very confident’ remaining up-to-date with advances in HIV care, assessing patient/client substance use/abuse, managing ART adverse effects, and providing evidence-based group HIV prevention interventions. Table 72 and Table 73 display confidence in providing services to PLWH by organization type in Michigan and Out State, respectively. Confidence in providing services varied by organization type and population group and no single organization type consistently fared better than another.

Table 71: Professionals ‘Very Confident’ Providing Services to persons living with HIV, Michigan, 2015

	Michigan		Out-State	
	n	%	n	%
Communicating HIV risk and transmission	80	90	48	91
Assessing patient/client sexual risk	74	83	49	92
Providing long-term HIV care	42	79	28	82
Providing evidence-based individual HIV prevention interventions	61	73	37	76
Assessing patient adherence to drug regimens	52	71	32	74
Assessing when to begin therapy	36	65	23	64
Providing general medical care unrelated to HIV	33	63	22	76
Providing evidence-based group HIV prevention interventions	44	59	28	60
Managing ART adverse effects	29	58	17	55
Assessing patient/client substance use/abuse	49	58	31	60
Remaining up-to-date with advances in HIV care	46	58	28	57
Providing dental screening and care	16	50	9	45
Treating chronic hepatitis	16	38	13	48
Professionals who indicated that they did not provide the service were excluded from the analysis				

Table 72: Professionals ‘very confident’ providing services to persons living with HIV by organization type, Michigan, 2015

	HIV Specialty %	CBO %	Health Dept. %	Hospital %	FQHC/C HC %	Other %
Communicating HIV risk and transmission	95	100	100	100	70	80
Assessing patient/client substance use/abuse	58	36	72	71	70	57
Assessing patient/client sexual risk	90	94	100	71	80	67
Providing evidence-based group HIV prevention interventions	71	64	67	40	50	55
Providing evidence-based individual HIV prevention interventions	84	87	75	67	60	67
Providing dental screening and care	60	25	50	0	67	56
Providing long-term HIV care	94	83	75	80	71	64
Providing general medical care unrelated to HIV	82	75	100	0	71	54
Treating chronic hepatitis	50	0	50	40	29	36
Assessing when to begin therapy	79	43	75	100	50	67
Managing ART adverse effects	82	33	57	80	43	46
Assessing patient adherence to drug regimens	83	73	69	100	56	60
Remaining up-to-date with advances in HIV care	89	50	57	80	36	44

Professionals who indicated that they did not provide the service were excluded from the analysis

*Other includes urgent care (n=1), department of corrections (n=4), physician practice group (n=3), specialty pharmacy (n=2), specialty pharmacy (n=2), sexual assault examiners (n=2), home care agency (n=1), tribal clinic (n=1), community mental health center (n=1), behavioral health services center (n=1), research center (n=1), solo practice (n=1), general practice (n=1); school-based clinic (n=1), medical school (n=1).

Table 73: Professionals ‘very confident’ providing services to persons living with HIV by organization type, Out State, 2015

	HIV Specialty %	CBO %	Health Dept. %	Hospital %	FQHC/C HC %	Other %
Communicating HIV risk and transmission	92	100	100	100	75	80
Assessing patient/client substance use/abuse	50	22	75	100	75	75
Assessing patient/client sexual risk	92	100	100	100	88	80
Providing evidence-based group HIV prevention interventions	70	75	62	50	63	20
Providing evidence-based individual HIV prevention interventions	91	88	71	100	75	40
Providing dental screening and care	33	0	60	0	75	67
Providing long-term HIV care	89	100	75	100	83	50
Providing general medical care unrelated to HIV	67	100	100	0	83	50
Treating chronic hepatitis	80	0	50	100	33	25
Assessing when to begin therapy	78	50	75	100	57	50
Managing ART adverse effects	86	40	57	50	50	25
Assessing patient adherence to drug regimens	82	86	73	100	57	60
Remaining up-to-date with advances in HIV care	100	50	58	50	44	17

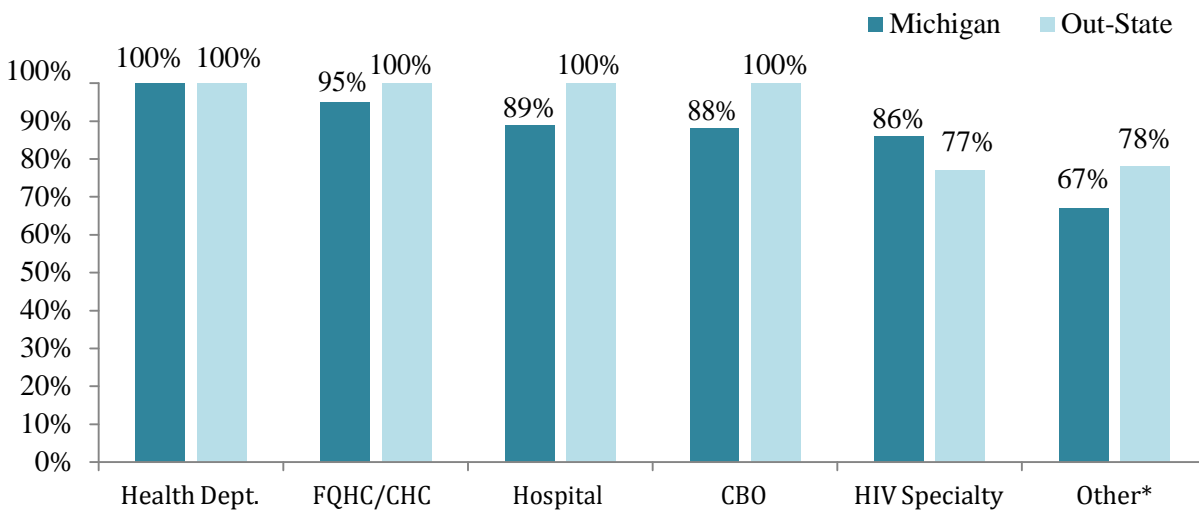
Professionals who indicated that they did not provide the service were excluded from the analysis

*Other includes urgent care (n=1), department of corrections (n=4), physician practice group (n=3), specialty pharmacy (n=2), specialty pharmacy (n=2), sexual assault examiners (n=2), home care agency (n=1), tribal clinic (n=1), community mental health center (n=1), behavioral health services center (n=1), research center (n=1), solo practice (n=1), general practice (n=1); school-based clinic (n=1), medical school (n=1).

4.1.4 ORGANIZATIONAL TESTING AND PARTNER SERVICES

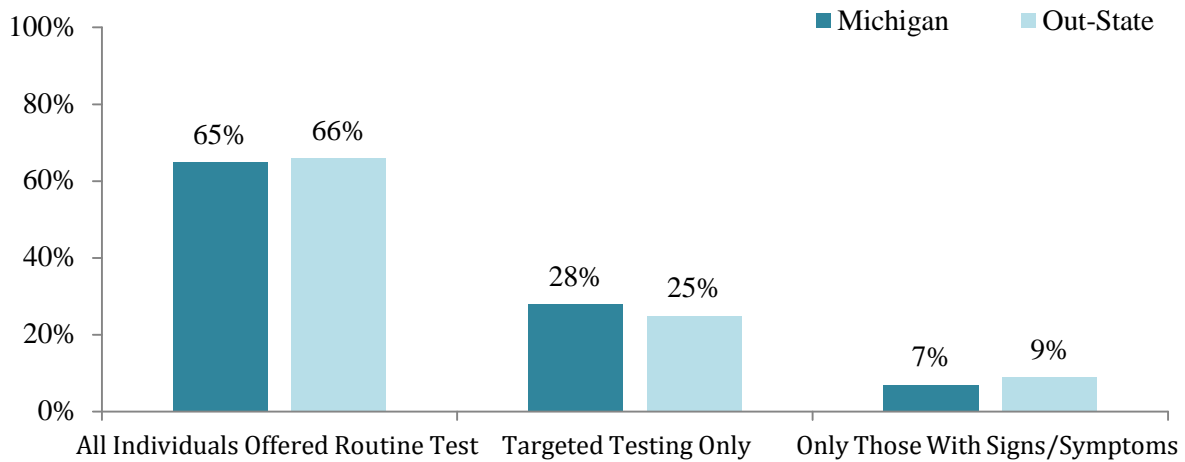
One hundred five professionals (66%) indicated that their organization did conduct HIV tests. Most organization types conducted HIV testing except for 'other' organizations in which only 67% of professionals indicated that testing was conducted (Figure 30); please see footnote below figure 26 for clarification of what these 'other' organizations were. Sixty-five percent of professionals indicated that their organization routinely offered testing to all individuals, 28% of professionals said that their organization conducted targeted testing only, and 7% of professionals said that their organization only conducted testing when there were clinical signs or symptoms of HIV infection (Figure 31).

Figure 30: Organizations that conduct HIV testing by organization type, Michigan, 2015



* Other includes urgent care (n=1), department of corrections (n=4), physician practice group (n=3), specialty pharmacy (n=2), specialty pharmacy (n=2), sexual assault examiners (n=2), home care agency (n=1), tribal clinic (n=1), community mental health center (n=1), behavioral health services center (n=1), research center (n=1), solo practice (n=1), general practice (n=1); school-based clinic (n=1), medical school (n=1).

Figure 31: When organization offers HIV tests, Michigan, 2015



Professionals were asked to choose from a list of barriers which they thought were they most significant to offering testing for HIV. The two most significant barriers were ‘patients/clients do not want to be tested’ and ‘patients/clients don’t view HIV as a pressing issue’ (Table 74). Other barriers include ‘reimbursement for HIV testing is low or unavailable’, ‘there isn’t enough time during the visit to provide HIV testing’, and ‘providers are uncomfortable discussing HIV with patients/clients’. There was an option for professionals to add barriers that were not listed as an ‘other, please specify’ choice. The common barriers mentioned by professionals were related to clients. Stigma, fear, and client concern about confidentiality were commonly cited. Other barriers mentioned were a lack of human and financial resources, patient partners refusing testing, quality checks and additional paper work for rapid testing being burdensome, lack of staff training, and the difficulty of identifying targeted risk groups.

Table 74: Barriers to offering HIV tests, Michigan, 2015

	Michigan		Out-State	
	n	%	n	%
Our patients/clients do not want to be tested	30	34	18	33
Our patient/clients don't view HIV as a pressing issue	28	31	20	36
Reimbursement for HIV testing is low or unavailable	19	21	14	25
There isn't enough time during the visit to provide HIV testing	12	13	10	18
We have no barriers	11	12	3	5
Our providers are uncomfortable discussing HIV with patients/clients	9	10	8	15
Our providers don't view HIV as a pressing issue for our patients/clients	8	9	6	11
Other*	26	29	15	27
Total^	89		55	

^Categories are not mutually exclusive

*Other includes: Clients’ fear/stigma/concern about confidentiality, lack of resources (human and monetary), partners refuse testing, quick testing poses barriers, lack of stack training, identification of targeted risk group

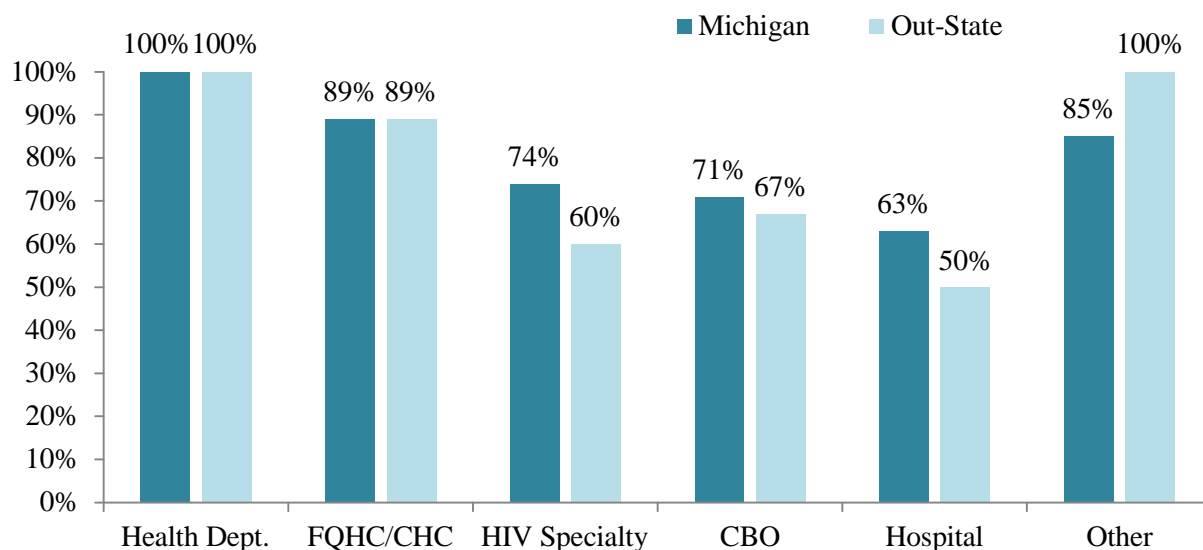
A. Partner Services

Over 80% of organizations that conducted HIV testing collected partner information to offer or refer clients to partner services; 46% of organizations collected information and offered partner services and 37% collected information and referred out to partner services (Table 75). Of the organizations that conducted HIV tests, 81% did have a plan in place to ensure at-risk partners were notified and tested. Hospitals, CBOs, and HIV clinical specialty care organizations were less likely to have a plan in place to ensure at-risk partners were notified and tested compared to other organization types (Figure 32).

Table 75: Partner services among organizations that offer HIV tests, Michigan, 2015

	Michigan		Out-State	
	n	%	n	%
Collect partner information for partner services when client test positive for HIV				
Yes and offer partner services	46	46	31	51
Yes and refer out for partner services	37	37	18	30
Do not collect partner services information	17	17	12	20
Organization has a plan in place to ensure at-risk partners are notified and tested				
Yes	81	81	50	82
No	19	19	11	18

Figure 32: Organization has a plan in place to ensure at-risk partners are notified and tested by organization type, Michigan, 2015



*Other includes urgent care (n=1), department of corrections (n=4), physician practice group (n=3), specialty pharmacy (n=2), specialty pharmacy (n=2), sexual assault examiners (n=2), home care agency (n=1), tribal clinic (n=1), community mental health center (n=1), behavioral health services center (n=1), research center (n=1), solo practice (n=1), general practice (n=1); school-based clinic (n=1), medical school (n=1).

4.1.5 ORGANIZATIONAL BARRIERS

Professionals were asked to choose from a list of organizational barriers which they thought were most significant barriers to providing medical, dental, or support services to persons living with HIV. The most significant organizational barrier was ‘insurance coverage concerns’ (Table 76). Other barriers included ‘lack of staff time to provider services’, ‘limited reimbursement for services’, and ‘lack of referral partners for services not offered in our organization’. There was an option for professionals to add barriers that were not listed as an ‘other, please specify’ choice. The common barriers mentioned among professionals were a lack of patient transportation, a lack of external providers with the knowledge of how to treat HIV patients to refer patients to, long wait times for a specialist, and limited dental services available.

Professionals were asked to choose from a list of organizational barriers which they thought were the most significant barriers to linking patients/clients to HIV medical care. The most significant organizational barrier was ‘patient/client resistance’ (Table 77). Other common barriers include ‘difficulty getting clients into specialty care’, ‘limited staff time’, and ‘limited amount of dedicated funding’. There was an option for professionals to add barriers that were not listed as an ‘other, please specify’ choice. The common barriers cited by professionals were lack of transportation, limited providers/services in our area, lack of patient confidentiality or privacy, patient denial and uncertainty at initial diagnosis, difficulty to ensure continuity of care once patient is released, and distance to infectious disease and primary care doctors.

Table 76: Organizational barriers to providing medical, dental, or support services, Michigan, 2015

	Michigan		Out-State	
	n	%	n	%
Insurance coverage concerns	43	49	27	52
Lack of staff time to provide services	22	25	10	19
Limited reimbursement for services	21	24	12	23
Lack of referral partners for services not offered in our organization	18	20	15	29
Prior authorization concerns	17	19	9	17
Lack of available providers proficient in the provision of HIV care	15	17	7	13
Formulary restrictions	14	16	10	19
Other*	14	16	8	15
Lack of providers who are proficient in the provision of evidence-based interventions of persons with HIV	11	13	11	21
Lack of cultural competency when communicating with patients	10	11	7	13
Lack of providers who are comfortable communicating with patients/clients with HIV	7	8	7	13
Sigma or avoidance of HIV issues among staff	4	5	3	6
Fail-first or step therapy concerns	1	1	0	0
Quantity limits	1	1	0	0
Total^	88		33	

^Categories are not mutually exclusive

Other includes: lack of patient transportation, a lack of external providers with the knowledge of how to treat HIV patients to refer patients to, long wait times for a specialist, and limited dental services available

Table 77: Organizational barriers to linking patients with HIV to medical care, Michigan, 2015

	Michigan		Out-State	
	n	%	n	%
Patient/client resistance	42	37	26	41
Difficult to get clients into specialty care	24	21	16	25
Limited staff time	20	17	14	22
Limited amount of dedicated funding	19	17	10	16
Limited staff knowledge/skills/experience	16	14	7	11
Inability to be reimbursed for linkage services	12	10	6	10
Services are not available in our area	10	9	8	13
We do not encounter barriers	9	8	5	8
No established procedure or protocol in place	5	4	1	2
Staff resistance to providing this service	5	4	1	2
Staff cultural competency/comfort with issue	5	4	2	3
Unsure where to refer patients/clients	5	4	1	2
Leadership resistance to providing this service	3	3	1	2
Other*	20	17	13	21
Total^				

^Categories are not mutually exclusive
 *Other includes: lack of transportation, limited providers/services in our area, lack of patient confidentiality or privacy, patient denial and uncertainty at initial diagnosis, difficult to ensure continuity of care once released, distance to infectious disease and primary care doctors

4.1.6 LINKAGES AND REFERRALS TO MEDICAL CARE

Of professionals whose organizations facilitate linkage to medical care, nearly all (96%) provide referrals to specific providers (Table 78). Other common ways PLWH are linked to medical care include scheduling appointments for patients/clients (77%), providing patients/clients with a list of local providers (77%), confirming that patients/clients attend appointments (63%), and providing early intervention services or other specific linkages (60%). Providing case management services and providing transportation services were cited as ways clients were linked to care in slightly over half of providers (52%).

Of professionals whose organizations facilitate linkage to support services, such as providing referrals, referring patients internally, and providing patients with lists of local support service providers, among other tasks, most (89%) provide referrals to specific providers (Table 78). Other common ways PLWH are linked to support services include referring patients/clients internally to care (79%), providing patients/clients with a list of local providers/services (73%), scheduling appointments for patients/clients (65%), and confirming that patients/clients attend appointments (60%). Providing case management services was cited by 56% of professionals and providing transportation assistance was cited by 49% of providers as ways clients were linked to support services.

Table 78: Linkage of HIV positive patients to medical care and support services, Michigan, 2015

	Michigan		Out-State	
	n	%	n	%
Linkage to Medical Care				
Provide referrals to specific providers	50	96	29	100
Schedule appointment for patients/clients	40	77	22	76
Provide patients/clients with a list of local providers/services	40	77	24	83
Confirm that the patient/client attended the appointment	33	63	21	72
Provide early intervention services or other specific linkages	31	60	19	66
Provide reminders about the upcoming appointments	28	54	18	62
Accompany patients/clients to appointments	28	54	16	55
Provide transportation assistance	27	52	18	62
Provide case management services	27	52	17	59
Provide translation services	23	44	15	52
Refer patients/clients internally to care	15	29	8	28
Other*	1	2	0	0
Total^	52		29	
Linkage to Support Services				
Provide referrals to specific providers	95	89	57	93
Refer patients/clients internally to care	85	79	50	82
Provide patients/clients with a list of local providers/services	78	73	50	82
Schedule appointment for patients/clients	70	65	40	66
Confirm that the patient/client attended the appointment	64	60	44	72
Provide early intervention services or other specific linkages	61	57	41	67
Provide case management services	60	56	41	67
Provide reminders about the upcoming appointments	54	50	39	64
Provide transportation assistance	52	49	39	64
Provide translation services	50	47	37	61
Accompany patients/clients to appointments	36	34	24	39
Other*	5	5	2	3
Total^	107		61	
^Categories are not mutually exclusive				
*Other linkage to medical care includes referring clients for transportation assistance, EIS and case management services				
*Other linkage to support services includes linking patients to EIS, providing medical care, providing referrals to HIV support service organizations, and referring to specific local organizations				

4.1.7 PERSPECTIVES ON PATIENT EXPERIENCES

Thirty-three percent of professionals said that their organizations had no wait times for appointments for new patients with HIV (Figure 33). Approximately 32% of professionals said that the wait time for new patients with HIV was less than one week, 27% of professionals said the wait times were 1 to 2 weeks, and 8% of professionals said the wait times were more than 3 weeks. Out State respondents indicated slightly longer wait times for patients with HIV than in Michigan overall. In Out State, 29% of professionals said there was no wait time, 31% of professionals said the wait time was less than one week, 35% of professionals indicated a wait time of 1 to 2 weeks, and 6% of professionals said the wait times was more than 3 weeks. A greater percentage of CBOs, health departments, and other organization types had appointment wait times that were less than one week compared to other organization types (Figure 34). Less than half of the professionals representing HIV clinical specialty care organizations reported that appointment wait times were less than one week. In Out State, only 23% of professionals representing HIV clinical specialty care organizations reported appointment wait times less than one week. Professionals were asked to choose from a list of barriers they considered the most significant for patients/clients with HIV seeking services from their organization (Table 79). Transportation was noted as the most significant patient barrier by 51% of professionals. Other barriers noted were mental illness (46%), HIV stigma (40%), patient/client non-compliance (40%), and substance abuse (36%).

Figure 33: Appointment wait time for new patients with HIV, Michigan, 2015

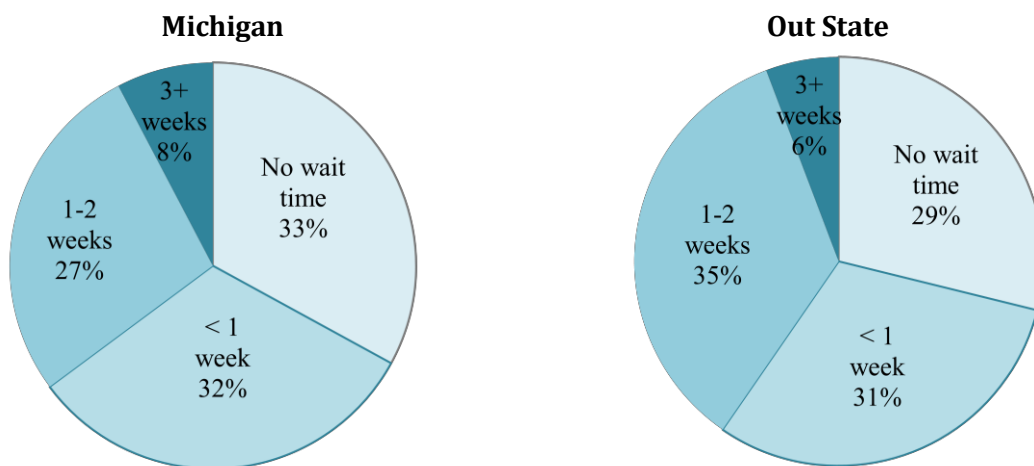
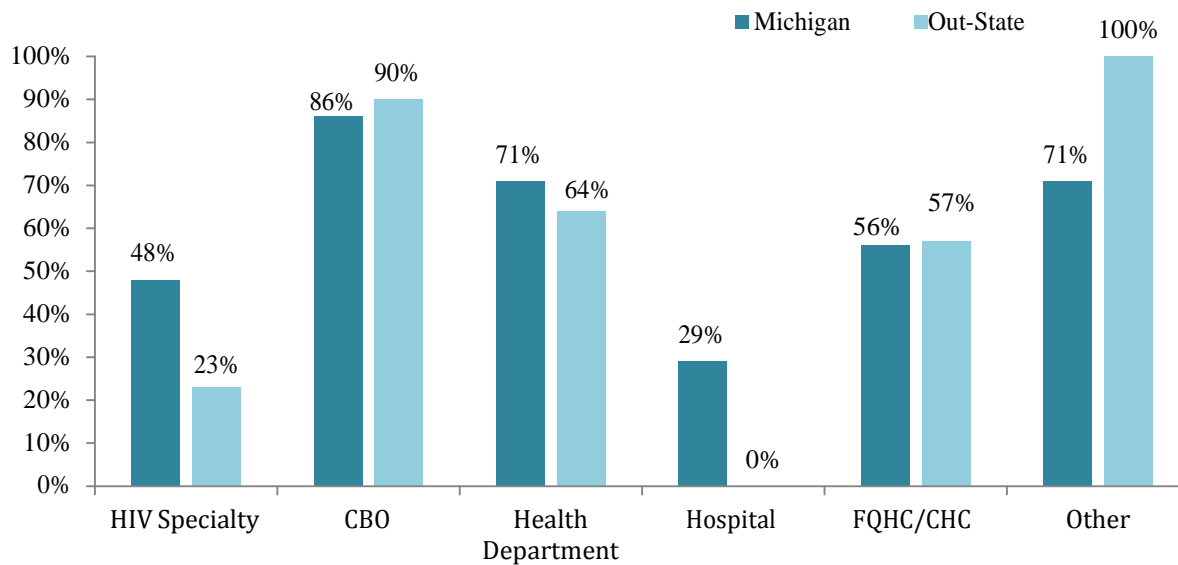


Figure 34: Appointment wait times that are less than one week for new patients with HIV by organization type, Michigan, 2015



*Other includes urgent care (n=1), department of corrections (n=4), physician practice group (n=3), specialty pharmacy (n=2), specialty pharmacy (n=2), sexual assault examiners (n=2), home care agency (n=1), tribal clinic (n=1), community mental health center (n=1), behavioral health services center (n=1), research center (n=1), solo practice (n=1), general practice (n=1); school-based clinic (n=1), medical school (n=1).

Table 79: Provider perspectives on barriers for patients seeking HIV care or services, Michigan, 2015

	Michigan		Out-State	
	n	%	n	%
Transportation issues	56	51	30	48
Mental illness	50	46	31	50
HIV stigma	44	40	33	53
Patient/client non-compliance	44	40	26	42
Substance abuse	39	36	25	40
Ability to pay	11	10	7	11
Housing insecurity	7	6	4	6
Other	6	6	1	2
Lack of provider sensitivity to client/patient gender identity	5	5	4	6
Location of HIV treatment centers	5	5	2	3
Childcare	3	3	1	2
Total^	109		62	

^Categories are not mutually exclusive

4.1.8 MEDICATION PRACTICES

A. Prescription of Pre-Exposure and Post-Exposure Prophylaxis

Of survey respondents, 22% indicated that they did prescribe medications that prevent HIV infection or treat current HIV infections (Table 80). Of these, 67% had ever prescribed continuous daily dosing of Truvada for pre-exposure prophylaxis (PrEP) of HIV infection and 54% had ever prescribed antiretroviral medication for non-occupational post-exposure prophylaxis (nPEP). Eighty-one percent of providers prescribed PrEP to men who have sex with men, 69% of providers prescribed PrEP for women who have sex with men, and 56% of providers prescribed PrEP for uninfected partners in serodiscordant couples attempting to conceive. Seventy-seven percent of providers prescribed nPEP for survivors of sexual assault, 69% of providers prescribed nPEP for women who have sex with men, 54% of providers prescribed nPEP for men who have sex with men, and 46% of providers prescribed nPEP for men who have sex with women.

Table 80: Prescription of pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (nPEP), Michigan, 2015

	Michigan		Out-State	
	n	%	n	%
Prescribe patients medications that prevent HIV infection or treat current HIV infections				
Yes	24	22	10	16
No	85	78	52	84
Ever prescribed continuous daily dosing of tenofovir/emtricitabine (Truvada) for pre-exposure prophylaxis (PrEP) of HIV infection				
Yes	16	67	9	90
No	8	33	1	10
For whom have you prescribed continuous daily dosing of tenofovir/emtricitabine (Truvada) for PrEP				
Men who have sex with men	13	81	8	89
Women who have sex with men	11	69	5	56
Uninfected partners in serodiscordant couples trying to conceive	9	56	5	56
Men who have sex with women	6	38	3	33
Sex workers	5	31	2	22
Other	3	19	1	11
Transgender women	2	13	0	0
Transgender men	2	13	1	11
Injecting drug users	2	13	1	11
Total^	16		9	
Ever prescribed antiretroviral medication for non-occupational post-exposure prophylaxis (nPEP)				
Yes	13	54	6	60
No	11	46	4	40
For whom have you prescribed antiretroviral medication for nPEP?				
Survivors of sexual assault	10	77	3	43
Women who have sex with men	9	69	4	57
Men who have sex with men	7	54	3	43
Men who have sex with women	6	46	3	43
Sex workers	3	23	2	29
Transgender women	2	15	0	0
Transgender men	1	8	0	0
Uninfected partners in serodiscordant couples trying to conceive	1	8	1	14
Other	1	8	1	14
Injecting drug users	0	0	0	0
Total	13		6	
^Categories are not mutually exclusive				

B. Opioid Safety

Providers were given a series of statements and asked to indicate their personal perspective on barriers to implementing opioid safety training with naloxone for HIV positive patients and patients considered at-risk for HIV infection (Table 81). Seventy-three percent of providers did indicate that their patients received prescriptions for opioids and/or were at risk of overdose. The majority of providers were comfortable discussing opioid safety with their patients (78%). However, there was a lack of awareness of the programs available to providers. Sixty-five percent of professionals disagreed or did not know about screening tools for overdose risk and 65% of professionals disagreed or did not know about programming to address opioid overdose. Concerns about costs (68%) and concerns about patients discussing opioid use honestly (78%) were additional barriers identified.

Table 81: Professional awareness and beliefs on opioid safety training with Naloxone for HIV positive patients and patients at-risk for HIV infection, Michigan, 2015

	Michigan		Out-State	
	n	%	n	%
Concerned about costs and reimbursement for training and access to naloxone rescue kits				
Agree	28	68	21	68
Disagree	13	32	10	32
My patients do not receive prescriptions for opioids and/or are not at risk of overdose				
Agree	15	27	5	15
Disagree	41	73	29	85
Aware of screening tools for overdose risk				
Agree	27	35	16	32
Disagree/Don't Know	51	65	34	68
Aware of programming to address opioid overdose				
Agree	27	35	18	37
Disagree/Don't Know	50	65	31	63
Comfortable discussing opioid use and possible substance abuse with my patients				
Agree	62	78	35	74
Disagree	17	22	12	26
Concerned my patients won't discuss opioid use and other substance use honestly with me				
Agree	57	72	36	75
Disagree	22	28	12	25
Professionals who indicated that the statement was not applicable to their practice and those who responded 'Don't Know' were excluded from the analysis unless otherwise indicated				

4.1.9 EDUCATIONAL TOPICS OF INTEREST

Table 82 presents a list of the educational topics of interest to professionals who provide care or support services to patients/clients with HIV. When asked about education needs, providers indicated that retention in care, mental health care, PrEP/nPEP, management of co-infections, sexual health behavioral assessments, LGBTQ sensitivity training, opioid substitution therapy, antiretroviral therapy, diagnosis and treatment for opportunistic infections, and HIV treatment education were the top ten topics of most interest.

Table 82: Educational topics of interest among providers, Michigan, 2015

	Michigan		Out-State	
	n	%	n	%
Retention in care	42	40	24	40
Mental health care	42	40	26	43
PrEP/nPEP	40	38	21	35
Management of co-infections	38	36	19	32
Sexual health behavioral assessments	38	36	20	33
LGBTQ sensitivity training	34	32	19	32
Opioid substitution therapy	34	32	22	37
Antiretroviral therapy	28	27	13	22
Diagnosis and treatment for opportunistic infections	27	26	14	23
HIV treatment education	22	21	14	23
STI screening and treatment	18	17	14	23
HIV rapid testing	17	16	12	20
HIV prevention counseling	15	14	6	10
Other	7	7	3	5
Total^	105		60	

^Categories are not mutually exclusive

Other includes: motivational interviewing, services and support services available, smoking cessation, stigma management, tobacco and HIV, transgender specific care needs, always want more knowledge seminars

SECTION 4.1 SUMMARY: SURVEY OF PROFESSIONALS WHO PROVIDE CARE AND SERVICES TO PERSONS LIVING WITH HIV/AIDS IN MICHIGAN

- In 2015, a self-administered online survey was completed by 159 medical and service providers in Michigan. This survey is not representative of all Michigan providers. Data from this survey should be used in addition to other secondary data sources.
- Nearly half of respondents were nurses, nurse practitioners, or advanced practice nurses and over 60% of respondents had 11 years or more experience in their field.
- The majority of respondents were female, White, and heterosexual. Twenty percent of respondents were Black/African American and 4% were Asian. Nine percent of respondents identified as men who have sex with men.
- Since the implementation of the Healthy Michigan Plan and Medicaid expansion, 44% of providers said that demand for services increased, 53% said demand stayed the same, and 3% said that demand decreased.
- Approximately 42% of professionals in Michigan experienced burdens due to the implementation of the Affordable Care Act and Medicaid expansion. The greatest burden identified was an increased workload due to increased volume of patients and an increased time and complexity to accessing insurance.
- Most professionals were very confident in the provision of most services offered to PLWH, but not all. Only half of professionals surveyed were 'very confident' in providing dental screening and care to PLWH and only 38% of professionals were 'very confident' in treating chronic hepatitis.
- The two most commonly cited organizational barriers to testing were that patients/clients do not want to be tested and that patients/clients don't view HIV as a pressing issue.
- Over 80% of organizations that conduct HIV testing collected partner information to offer or refer clients to partner services; 46% of organizations collected information and offered partner services and 37% collected information and referred out to partner services. The majority of organizations that conduct HIV tests do have a plan or protocol in place to ensure at-risk partners are notified and tested.
- The most common organizational barrier to providing medical care and support services was insurance coverage concerns.
- The most common organizational barrier to linking patients with HIV to medical care was patient/client resistance.
- Providing referrals to specific providers was the most frequently cited method of linking patients to medical care and linking to support services.
- Thirty-three percent of professionals said that their organizations had no wait times for appointments for new patients with HIV; 8% said wait times were more than 3 weeks.
- Providers cited transportation, mental illness, HIV stigma, and patient/client non-compliance as the most significant barriers to patients seeking HIV care or services.
- Seventy-three percent of providers did indicate that their patients received prescriptions for opioids and/or were at risk of overdose. The majority of providers were comfortable discussing opioid safety with their patients. However, there was a lack of awareness of the programs and tools available to providers to address opioid overdose.

SECTION 4.2 MICHIGAN JAIL HIV EVALUATION

A formative evaluation to obtain information on HIV testing and care processes in Michigan county jails was conducted between May 2015 and August 2015. Based on convenience sampling, a semi structured interview was administered to Local Health Department (LHD) staff. These staff have some sort of relationship with the jails in five high incidence counties in the following prosperity regions (PR); 10, 9, 6, and 4. Phone interviews lasting approximately 30 minutes were completed. When recommended, staff from partnering Community Based Organizations (CBOs) were also contacted and interviewed. As such, a few additional interviews were conducted with CBO staff in prosperity regions 10 and 6. Data that was collected is provided to establish a picture of the current state of Michigan jails' processes in working with persons living with HIV. This is not a complete representation of all Michigan jails and cannot be generalized to all county jails. This interview was the first step in evaluating HIV testing and care procedures within county jails as well as their linkage to care once they are released. Findings will provide baseline data for more in-depth data collection for additional evaluation projects. To ensure confidentiality the jails in each region will be denoted as such: PR 10- Jail A and Jail B, PR 9- Jail C, PR 6- Jail D, and PR 4- Jail E.

4.2.1 HIV TESTING

The county jail in PR 10, Jail A has any individual who has never been tested and individuals who meet high-risk behavior criteria tested through the partnering University. Another jail in PR 10, Jail B conducts all HIV testing due to health department staff not being allowed to bring in sharps. In PR 9, Jail C, weekly HIV and STI testing and counseling is completed by the health department for individuals that request to be seen. In PR 6, a community based organization is contacted by Jail D, if there is an individual who is HIV positive. The CBO conducts all testing in PR 6 county jails with testing devices and lab use that is provided by the health department, but this is not a routine procedure. In PR 4, Jail E has, a jail certified nurse conducts HIV testing. The health department is involved when there is a health threat and the jail needs proof of an HIV positive client.

4.2.2 PROCESS OF WORKING WITH HIV POSITIVE INDIVIDUALS

In Jail A, a local CBO comes in once a week to work with HIV positive individuals. They begin working with incarcerated individuals before they are released, and continue that relationship after they have been released into their respective jurisdiction. The university also provides counseling services. In Jail B medical regimens are continued by non-ID physicians. An ID physician only sees patients when their CD4 count is below a certain level. All other services are provided after the individual is released by a local health service agency if they are contacted. Jail C allows individuals who enter the system HIV positive to continue care with their home physician while incarcerated. Jail staff are only aware of someone being diagnosed if the client tells them. In Jail D the CBO provides most services to individuals with HIV while they are incarcerated. A correctional health system and the health department provide some supportive services. In Jail E, the jail nurses and ID Specialists continue care for individuals throughout incarceration

4.2.3 PROCESS OF WORKING WITH NEWLY DIAGNOSED INDIVIDUALS

In Jail A, the CBO provides case management after a client is diagnosed as HIV positive. Case managers come into the jail and establish a working file. The CBO only coordinates social services that the jail social service employees have not. They assist with these services once a client is released. This strategy alleviates issues experienced when a client is released without staff knowing. Individuals who reside in a different jurisdiction continue working with a case manager and the CBO acts as a liaison. In jail B they contact the health department when an individual is diagnosed with HIV, however this has only occurred twice in the past 6 months. When an individual is newly diagnosed in Jail C, the health department is contacted and sends a referral to the on-staff physician who determines when care starts. The local CBO provides case management services only if the client contacts them. Jail D contacts the CBO after an individual tests positive. The CBO provides most services to individuals with HIV while they are incarcerated. A correctional health system and the health department provide supportive services and a healthcare agency and CBO provide case management services. In Jail E, newly diagnosed individuals are linked to a partnering health care facility Infectious Disease physician through the health department. The jail nurses and ID Specialists continue care for individuals throughout incarceration. The local CBO and Infectious Disease provider offer other social services to those incarcerated. Jail E provides case management only to newly diagnosed clients and has no formal processes for providing or linking to social services upon the release of an individual.

4.2.4 ACCESS TO HIV MEDICATIONS WHILE INCARCERATED AND UPON RELEASE

Jail A provides medications throughout incarceration period and provides a 2 week supply upon release. If an individual is released without staff knowing, the CBO can contact the individual to facilitate access to medications. Jail B suffers a 3-4 week lag in the provision of HIV medications to individuals that are incarcerated and sometimes inmates are discharged without access to medications. In Jail C a nurse practitioner can provide guidance on which medication regiment is appropriate, but can't prescribe medications. For individuals already diagnosed, medical staff continues regimented medications. A specialist is referred when an individual is newly diagnosed to prescribe medications. A specialist also must prescribe any new or changes in medications. In jail D the local CBO provide treatment for HIV+ individuals. In Jail E, medications are handled through jail nurses.

4.2.5 CONTINUATION OF CARE/LINKAGE TO COMMUNITY BASED ORGANIZATIONS/AIDS SERVICE ORGANIZATIONS UPON RELEASE

Some of the county jails partner with a CBO or LHD in which they establish care while individuals are still incarcerated and to facilitate the continuation of care upon release. They may come into the jail once a week to work with HIV positive individuals. Specifically the health department acts as a liaison between community-based organizations and those who are incarcerated in Jail A and B. In Jail B, a service agency can contact the individual after they are released to conduct case management and provide information on social services, However if there is no release date on a client, the health department is unable to link them to the service agency. Ideally this communication has been facilitated between the individual and service agency by the health department for a smooth transition.

4.2.6 BARRIERS TO CARE

Each county experiences unique barriers to care that need to be recognized for future programming. The two largest issues within the jails are their relationship with the LHD and stigma or confidentiality issues among the correctional staff and the detainees. Inmates are not comfortable receiving services due to not feeling that their status is confidential. In many of the county jails interviewed, there is a lack of trust and communication between the jail and LHD staff, such as, the LHD is only contacted when the jail identifies an individual as being HIV positive and is not notified of their release. This disconnect makes it difficult to coordinate services. Furthermore the LHD may not be allowed to enter the jail or do HIV testing if allowed access, due to issues with clinic space, procedures and medical supplies. Other issues include gaps in care due to the referral process. There is also a lag in ordering new medications, which can take up to 24 hours to order. Lastly, LHD staff reported that care is reactive rather than proactive and that care is not a priority unless there are active symptoms.

4.2.7 RECOMMENDATIONS

The following suggested recommendations were provided during the interviews to increase the access to, effectiveness and efficiency of services provided to individuals with HIV throughout Michigan while incarcerated and upon release. Nurses should to give an educational presentation on the benefits of HIV testing and the availability of linkage services at intake or at additional medical encounters. MDHHS could provide trainings to nurses and correction staff on HIV prevention and care education to aid in reducing stigma and confidentiality issues. The establishment of HIV testing as part of routine process for the identification newly diagnosed individuals upon entry. Individuals with HIV should be engaged in the jail setting, linked to community care and retained in HIV care for at least 6 months post- release. Medical and psychosocial services need to work together in order to link and retain individuals to care. Psychosocial services can work with the LHD if follow-up care is needed. All jails should work directly with a case management program. Medication, counseling, health education and housing assistance services should be provided by case managers and provide key linkage and engagement services.

Table 83. Comparison of jail services for individuals with HIV in jail system, Michigan, 2015

Jail A	Jail B	Jail C	Jail D	Jail E
HIV Testing				
<ul style="list-style-type: none"> • All at risk individuals and those who have never been are tested • Jail Staff 	<ul style="list-style-type: none"> • No information on who is tested or their process • Jail Staff conducts HIV testing 	<ul style="list-style-type: none"> • Individuals who request to be tested • LHD Staff 	<ul style="list-style-type: none"> • Individuals who request to be tested • Local Community Based Organization 	<ul style="list-style-type: none"> • No information on who is tested or their process • Jail Staff conducts HIV testing
Process of working with HIV positive individuals:				
<ul style="list-style-type: none"> • CBO comes in once a week to provide Case Management • Full time staff from the university and the area medical center when specialist is required 	<ul style="list-style-type: none"> • Medical regiments are continued by non-ID physician • An ID doctor is only called when a CD4 count is below a certain level 	<ul style="list-style-type: none"> • Continue with home physician employ a non-ID physician and NP upon request 	<ul style="list-style-type: none"> • The local CBO provides services and the jail health system 	<ul style="list-style-type: none"> • Jail nurses and the local ID Specialist
Process of working with newly diagnosed individuals:				
<ul style="list-style-type: none"> • CBO comes in once a week to provide case management 	<ul style="list-style-type: none"> • The Jail will call the LHD but this is extremely infrequent 	<ul style="list-style-type: none"> • A specialized is referred when individual is newly diagnosed 	<ul style="list-style-type: none"> • The local CBO is contacted and provides most services to the individuals while incarcerated • The Jail Health system also provides supportive 	<ul style="list-style-type: none"> • Case management is provided by the local CBO • Other services provided by the Infectious Disease provider
Medication				
<ul style="list-style-type: none"> • They are provided medication throughout the incarceration period and a 2 week supply upon release 	<ul style="list-style-type: none"> • There is a 3-4 week lag in the provision of HIV medications • Some inmates are discharged without access 	<ul style="list-style-type: none"> • NP can provide guidance on regiment but cannot prescribe • For HIV+ they continue regimented medications 	<ul style="list-style-type: none"> • Provided by the local CBO 	<ul style="list-style-type: none"> • Medications are handled by jail nurses
Release				
<ul style="list-style-type: none"> • Continue with the Case Manager from the CBO 	<ul style="list-style-type: none"> • A local Service Agency will contact after release 	<ul style="list-style-type: none"> • Linked with the CBO if a client contact them linked with mental health services 	<ul style="list-style-type: none"> • Linked with local CBO • Linked with mental health 	<ul style="list-style-type: none"> • No formal process for linking to social services upon release
Barriers				
<ul style="list-style-type: none"> • Funding 	<ul style="list-style-type: none"> • Lack of 	<ul style="list-style-type: none"> • Gaps in 	<ul style="list-style-type: none"> • LHD and jail very 	<ul style="list-style-type: none"> • Only one HIV

<ul style="list-style-type: none"> • Confidentiality issues • Stigma 	<p>communication and trust between LHD and the jail</p> <ul style="list-style-type: none"> • Confidentiality 	<p>referral process</p> <ul style="list-style-type: none"> • Lag in ordering new medication • No linkage to care upon release because staff is unaware of release date • Care is reactive not proactive 	<p>disconnected</p> <ul style="list-style-type: none"> • Testing is irregular 	<p>test counselor in the jail</p> <ul style="list-style-type: none"> • LHD used to assist but are understaffed
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SECTION 5: DESCRIPTION OF THE DETROIT METROPOLITAN AREA

The Health Status Assessment compiled existing (secondary) data to provide an understanding of the demographic characteristics populations affected by HIV/AIDS, and the incidence, prevalence and trends in HIV infection in the Detroit Metropolitan Area. This section describes the population demographics of DMA residents using secondary data sources.

5.1 OVERALL POPULATION

The Detroit Metropolitan Statistical Area (DMA) is comprised of Wayne, Oakland, Macomb, St. Clair, Monroe and Lapeer counties. Currently, there are 4,260,839 persons residing in the DMA and the combined population accounts for 43% of Michigan's population. Detroit, located in Wayne County, is the most populous city in Michigan and accounts for approximately 7% of Michigan's population.

5.2 RACE AND ETHNICITY

Table 84 displays the racial/ethnic distribution for each county in the DMA. Wayne County has the greatest percentage of Black/African American residents (39.5%) and the greatest percentage of Hispanic residents (5.4%) compared to the other DMA counties. The racial distribution in Oakland and Macomb counties is similar in that there is a large percentage of White, non-Hispanic residents (74.0% and 82.2%) and a smaller percentage of Black/African American, non-Hispanic residents (13.7% and 9.7%). Oakland and Macomb counties have the greatest percentage Asian residents (5.9% and 3.3%) compared to the other DMA counties. The majority of residents in Lapeer, Monroe, and St. Clair counties are White, non-Hispanic, although 4.3% of residents in Lapeer County, 3.2% of residents in Monroe County, and 3.0% of residents in St. Clair County are of Hispanic ethnicity.

Table 84. DMA population by race/ethnicity, 2011-2013

	Lapeer	Macomb	Monroe	Oakland	St. Clair	Wayne
Total Population	88,226	848,455	150,944	1,221,103	160,878	1,789,819
White, NH	92.6%	82.2%	92.2%	74.0%	91.9%	49.8%
Black/African American, NH	1.2%	9.7%	2.3%	13.7%	2.3%	39.5%
Hispanic	4.3%	2.4%	3.2%	3.6%	3.0%	5.4%
Asian/Pacific Islander	0.5%	3.3%	0.6%	5.9%	0.5%	2.7%
AI/AN	0.2%	0.2%	0.4%	0.2%	0.2%	0.3%
Some Other Race	1.2%	2.2%	1.3%	2.6%	2.1%	2.3%

NH=non-Hispanic, AI/AN=American Indian/Alaska Native

Source: U.S. Census, American Community Survey, 2011- 2013

5.3 AGE AND SEX

In the counties in the DMA, slightly less than half of residents are male and slightly more than half are female, with the exception of Lapeer County where there are slightly more male than female residents (Table 85). The age distribution for each county in the DMA is similar. Compared to the other counties in the DMA, the population in Wayne County is slightly younger (median 37.8 years) and the populations in Lapeer and St. Clair counties are slightly older (median 42.9 years and 42.5 years).

Table 85. DMA population by age and gender, 2011-2013

	Lapeer	Macomb	Monroe	Oakland	St. Clair	Wayne
Gender						
Male	50.3%	48.6%	49.1%	48.5%	49.6%	48.1%
Female	49.7%	51.4%	50.9%	51.5%	50.4%	51.9%
Age						
Median age (yrs)	42.9	40.6	41.4	40.7	42.5	37.8
Under 5 years	4.9%	5.5%	5.6%	5.6%	5.4%	6.5%
5 to 9 years	7.0%	6.2%	6.2%	6.2%	6.4%	6.6%
10 to 14 years	6.4%	6.5%	7.0%	6.7%	6.6%	7.0%
15 to 19 years	7.5%	6.4%	6.8%	6.7%	6.9%	7.1%
20 to 24 years	5.6%	6.2%	6.2%	5.6%	5.6%	7.3%
25 to 34 years	9.7%	12.2%	10.8%	12.1%	10.2%	12.2%
35 to 44 years	12.5%	13.3%	12.5%	13.4%	12.6%	12.9%
45 to 54 years	16.9%	15.5%	15.9%	15.8%	16.3%	14.3%
55 to 59 years	8.5%	7.1%	7.7%	7.5%	7.4%	7.1%
60 to 64 years	6.4%	6.2%	6.9%	6.3%	7.0%	5.8%
65 to 74 years	9.0%	7.9%	8.1%	7.8%	8.7%	7.0%
75 years and over	5.6%	7.0%	6.3%	6.3%	6.9%	6.2%

Source: U.S. Census, American Community Survey, 2011-2013

5.4 EDUCATIONAL ATTAINMENT

Table 86 presents educational attainment for residents age 25 years and older in the DMA and in Michigan. The percent of residents 25 years and older who have a high school degree or higher is similar for most counties in the DMA compared to Michigan. Compared to Michigan, Oakland County has a slightly greater percentage of residents with a high school degree or higher (93%) and Wayne County has a smaller percentage of residents with a high school diploma or higher (84%). There was more variation among counties for those with a Bachelor's degree or higher. The percentage of residents with a Bachelor's degree or higher ranged from 16% in St. Clair County to 43% in Oakland County. Educational attainment in the City of Detroit was lower than the overall average in Michigan.

Table 86: Educational attainment for ages 25 Years and older, DMA, 2009-2013

	Education Level	
	High School Graduate or Higher %	Bachelor's Degree or Higher %
Lapeer	90	17
Macomb	88	23
Monroe	89	18
Oakland	93	43
St. Clair	89	16
Wayne	84	21
Detroit	78	13
Michigan	89	26
Source: U.S. Census, American Community Survey, 2009-2013		

5.5 SOCIO-ECONOMIC STATUS

In 2013, the estimated proportion of people living in poverty in Michigan was 17%. The percentage of people living in poverty in the DMA ranged from 10% to 25% (Table 87). In the DMA, Wayne County had the greatest percentage of residents living in poverty (25%), which was more than the average percentage for Michigan. In the DMA, St. Clair County (16%) had the second highest percentage of residents living in poverty, followed by Macomb (13%), Monroe (13%), Lapeer (11%), and Oakland (10%) counties, which were all below the state average.

In 2013, the estimated proportion of people without insurance coverage in Michigan was 13%. The percentage of people without health insurance in the DMA ranges from 10% to 16% (Table 87). In the DMA, Wayne County had the greatest percentage of persons without health coverage (16%), which was more than the average percentage for Michigan. Approximately 12% of residents living in Lapeer, Macomb, and St. Clair counties and approximately 10% of residents living in Oakland and Monroe counties were uninsured.

Table 87. Socio-economic status, DMA, 2013

	Poverty	Uninsured
Lapeer	11.1%	12.0%
Macomb	13.4%	12.5%
Monroe	12.5%	10.5%
Oakland	10.2%	10.7%
St. Clair	15.8%	12.3%
Wayne	25.1%	15.8%
Michigan	17.0%	12.9%
Source: U.S. Census Bureau, Small Area Income and Poverty Estimates; U.S. Census Bureau, Small Area Health Insurance Estimates		

SECTION 5 SUMMARY: DESCRIPTION OF THE DETROIT METROPOLITAN AREA (DMA)

- The DMA is comprised of Wayne, Oakland, Macomb, St. Clair, Monroe and Lapeer counties. Currently, there are 4,260,839 persons residing in the DMA and the combined population accounts for 43% of Michigan's population. Detroit, located in Wayne County, is the most populous city in Michigan and accounts for approximately 7% of Michigan's population.
- Racial distribution varies among counties in the DMA. Wayne County has the greatest percentage of Black/African American residents and the greatest percentage of Hispanic residents compared to the other DMA counties. The majority of residents in Lapeer, Monroe, and St. Clair counties are White, non-Hispanic.
- Compared to the other counties in the DMA, the population in Wayne County is slightly younger (median 37.8 years) and the populations in Lapeer and St. Clair counties are slightly older (median 42.9 years and 42.5 years).
- The majority of the DMA's population has received a high school diploma or GED equivalent. The percentage of residents with a Bachelor's degree or higher ranged from 16% in St. Clair County to 43% in Oakland County.
- The percentage of people living in poverty in the DMA counties ranged from 10% to 25%. Wayne County had the greatest percentage of residents living in poverty, followed by the counties of St. Clair, Macomb, Monroe, Lapeer, and Oakland.
- The percentage of people without health insurance in the DMA counties ranged from 10% to 16%. Wayne County had the greatest percentage of persons without health coverage, which was more than the average percentage for Michigan. Approximately 12% of residents living in Lapeer, Macomb, and St. Clair counties and approximately 10% of residents living in Oakland and Monroe counties were uninsured.

SECTION 6. HIV/AIDS IN THE DETROIT METRO AREA

6.1. EPIDEMIOLOGIC OVERVIEW

The Health Status Assessment compiled existing (secondary) data to provide an understanding of the demographic characteristics populations affected by HIV/AIDS, and the incidence, prevalence and trends in HIV infection in the Detroit Metropolitan Area. This section provides an epidemiologic overview of HIV/AIDS in the DMA residents using secondary data sources.

6.1.1. HIV PREVALENCE IN THE DETROIT METRO AREA

Prevalence is the total number of persons currently living with a disease at one point in time. In the Detroit Metropolitan Area (DMA), HIV prevalence estimates include persons diagnosed with HIV infection while residents of one of the six counties, regardless of current residence, and include the number of reported cases living with HIV infection and the number of HIV infection cases that have not yet been tested (estimated at 14% of the total cases living with HIV infection).

In 2014, there were an estimated 16,190 persons with HIV living in Michigan. Of these, 10,476 (65%) were residing in the DMA (Table 88). Wayne County had the greatest number of HIV cases (7,498 cases) and the highest rate of infection in Michigan and in the DMA (425 cases per 100,000). The City of Detroit accounted for 78% of cases in Wayne County which is a rate of 800 cases per 100,000 persons. Following Wayne County, the greatest numbers of diagnosed cases of HIV infection in the DMA were in Oakland County (1,965), Macomb County (802), St. Clair County (97), Monroe County (77) and Lapeer County (37). In the DMA, Oakland County had the second greatest rate of HIV infection (159 cases per 100,000) followed by Macomb County (93 per 100,000 persons), St. Clair County (61 cases per 100,000), Monroe County (51 cases per 100,000), and Lapeer County (42 cases per 100,000).

Table 88: Prevalent HIV infection cases, by county of residence at diagnosis, DMA, 2014

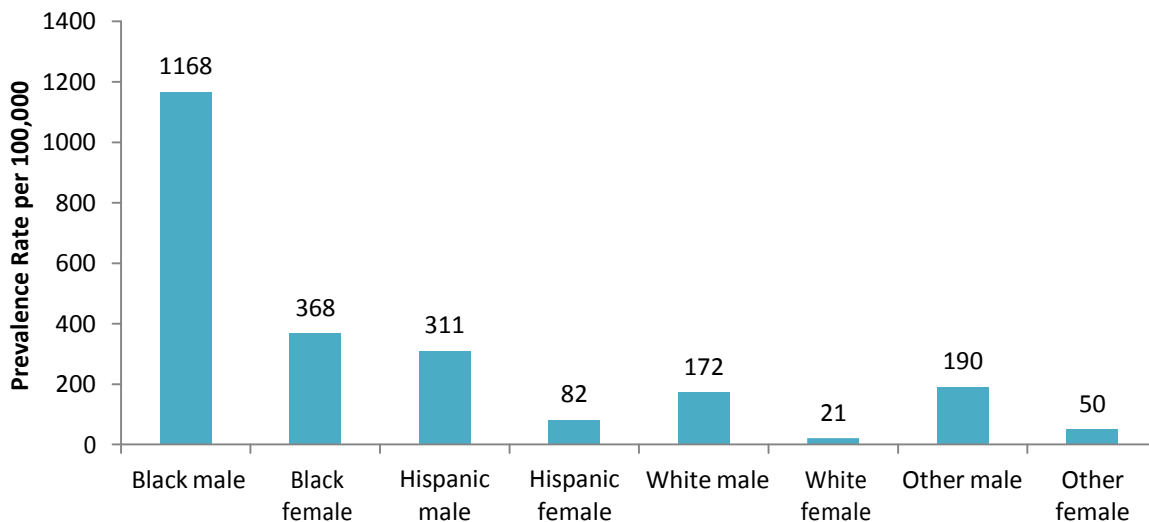
	Total Prevalence	Prevalence Rate
Lapeer	37	42
Macomb	802	93
Monroe	77	51
Oakland	1,965	159
St. Clair	97	61
Wayne	7,498	425
City of Detroit	5,854	800
Out Wayne	1,644	159
DMA Total	10,476	246
Michigan Total	16,190	163

Rate per 100,000

Source: Source: Michigan Department of Health and Human Services, *Annual HIV Surveillance Report, Southeast Michigan*; Published July 2015

Figure 35 presents the HIV prevalence rate by race/ethnicity and gender. In the DMA, the HIV prevalence rate is highest for Black males (1,168 per 100,000), followed by Black females (368 per 100,000), Hispanic males (311 per 100,000), males in other racial groups (190 per 100,000), and White males (172 per 100,000). White females had the lowest prevalence of HIV, with a rate of 21 cases per 100,000 population.

Figure 35: HIV prevalence rate by race/ethnicity and sex, DMA, 2014



Source: Michigan Department of Health and Human Services, *Annual HIV Surveillance Report, Southeast Michigan*; Published July 2015

Table 89 presents the distribution of HIV cases by age. Over 60% of cases in the DMA were among men and women between the ages of 20 and 40 years, with 33% being between the ages of 20 and 29 and 31% being between the ages of 30 and 39 years. Twenty percent of HIV cases were among men and women age 40 to 49 years. Eight percent of cases were among men and women 50 to 59 years and 6% of cases were among 13 to 19 year olds.

Table 89: Distribution of HIV cases by age, DMA, 2014

	N	%
0 - 12 years	128	1
13 - 19 years	622	6
20 - 29 years	3448	33
30 - 39 years	3257	31
40 - 49 years	2055	20
50 - 59 years	799	8
60 years and over	164	2
Unspecified	3	<1
Rate per 100,000		
Source: Source: Michigan Department of Health and Human Services, <i>Annual HIV Surveillance Report, Southeast Michigan</i> ; Published July 2015		

6.1.2. HIV TESTING IN THE DMA

Early diagnosis of HIV infection is essential to ensuring that persons are referred for evaluation, provided treatment, and linked into counseling and related support services to help them reduce their risk for transmitting HIV to others. In 2013, the U.S. Preventive Services Task Force (USPSTF) recommended that clinicians screen adolescents and adults ages 15 to 65 years for HIV infection. Younger adolescents and older adults who are at increased risk should also be screened. They recommend screening all pregnant women for HIV, including those who present in labor whose HIV status is unknown.

In Michigan an estimated 41% of adults aged 18 to 64 years reported being tested for HIV infection at least once in their lifetime (Table 90). In the City of Detroit, nearly 70% of adults reported having ever had an HIV test and 41% of adults in Wayne County, excluding the City of Detroit, reported having ever had an HIV test. Over 40% of adults residing in Oakland County, 39% of Macomb County residents, 37% of Lapeer County residents, 36% of St. Clair residents, and 33% of Monroe County residents reported ever having an HIV test.

Table 90: Ever had an HIV test by individual demographics, DMA, 2008-2010

	%
Michigan Total	41
Lapeer	37
Macomb	39
Monroe	33
Oakland	42
St. Clair	36
Wayne	
City of Detroit	69
Out Wayne	41
Out Wayne=Wayne county excluding the City of Detroit	
Source: Fussman C. 2014. 2011-2013 Michigan BRFSS Regional & Local Health Department Estimates, October 2014, Michigan Department of Health and Human Services,	

Annually, the Michigan Department of Health and Human Services (MDHHS) receives funding from the Centers for Disease Control and Prevention (CDC) to support HIV counseling and testing as well as other prevention interventions. In 2014, the HIV Prevention Program funded nearly 64,088 HIV tests for collaborating agencies in Michigan, with 43,546 tests (68%) occurring in the DMA (Table 91). In the DMA, the majority of tests were among African Americans and individuals aged 20 to 29 years. Approximately half of tests were among women, 49% among men, and less than 1% were among transgender individuals.

Table 91: MDHHS funded HIV testing by individual demographics, DMA, 2014

	N	%
Gender		
Female	21,922	50
Male	21,461	49
Transgender	163	< 1
Age (years)		
0-12	9	< 1
13-19	4,303	10
20-29	17,904	41
30-39	8,802	20
40-49	6,272	14
50-59	4,671	11
60+	1,585	4
Race		
African American	33,567	77
White	7,789	18
Other^	1,002	2
Unknown	1,188	3
DMA Total	43,546	
^Other race includes Arab, Asian, Native American, and Pacific Islander		
Source: Michigan Department of Health and Human Services, Counseling, Referral, and Testing (CTR) Data, 2014		

Table 92 presents MDHHS funded HIV testing by race and gender. Of the over 40,000 tests that occurred, African American females accounted for 17,504 tests, which was 41% of the total number of tests performed in the DMA in 2014. African American males accounted for 15,921 tests (38%). White males accounted for 4,479 tests (11%), White females accounted for 3,291 tests (8%), males of other racial groups accounted for 667 tests (2%), and females of other racial groups accounted for 334 tests (1%).

Table 92: MDHHS funded HIV testing by race and gender, DMA, 2014

	N	%
African American Female	17,504	41
African American Male	15,921	38
White Male	4,479	11
White Female	3,291	8
Other Male	667	2
Other Female	334	1
African American Transgender	142	< 1
White Transgender	19	< 1
Other Transgender	1	< 1
Total	42,358	
^Other race includes Arab, Asian, Native American, and Pacific Islander		
Note: Individuals with unknown race were excluded from the analysis (n=1,923)		
Source: Michigan Department of Health and Human Services, Counseling, Referral, and Testing (CTR) Data, 2014		

Table 93 presents MDHHS funded HIV testing by agency demographics. The CDC provides Category A funding for HIV prevention programs for health departments. Category A funded agencies, consisting of local health departments and MDHHS funded community based organizations (CBOs), accounted for 56% of testing that occurred in the DMA in 2014. The CDC provides Category B funding for expanded HIV testing for disproportionately affected populations. Category B funded agencies, consisting of five agencies serving the City of Detroit (Advantage Health Centers, Detroit Community Health Connection, Detroit Receiving Hospital, Henry Ford Health System, and Wayne State University), accounted for 44% of testing that occurred in 2014. Eighty-five percent of tests were in healthcare settings and 15% of tests were in non-healthcare settings; health care settings include those in which both medical diagnostic and treatment services are provided, while non-healthcare settings do not provide both medical diagnostic and treatment services and are also known as non-clinic settings. Specifically, 30% of tests occurred in STI clinics, 35% of tests occurred in emergency departments, 12% of tests occurred in other primary care facilities, 10% of tests occurred in CBOs and other service organizations, 5% of tests occurred in other public health clinics, and 5% of tests occurred in other non-healthcare settings.

Table 93: MDHHS funded HIV testing by agency demographics, DMA, 2014

	N	%
Funding		
Category A	24,589	56
Category B	18,957	44
Setting		
Healthcare	37,216	85
Non-Healthcare	6,330	15
Type		
STI Clinics	13,226	30
Emergency Departments	15,380	35
Other Primary Care Clinics	5,154	12
CBOs and Other Service Orgs.	4,487	10
Other Public Health Clinics	2,027	5
Other Non-healthcare Settings	2,118	5
Substance Abuse Treatment Facilities	1,000	2
Other Healthcare Settings	142	< 1
Community Health Centers	12	< 1
DMA Total	43,546	100
CBO=Community-based organization		
Source: Michigan Department of Health and Human Services, ,		
Counseling, Referral, and Testing (CTR) Data, 2014		

Of the 43,546 funded tests performed in the DMA in 2014, 43,186 tests (99%) were found to be negative, 358 tests were positive (0.8%), 17 tests had no result and 3 tests were indeterminate (Table 94). Of the 358 positive tests results, 76% were from category A funded agencies and 24% were from category B funded agencies. More than half were performed in a healthcare setting and 44% were performed in a non-healthcare setting. Of the 358 positive tests, 109 tests were performed in STI clinics (30%), 79 tests were performed in other non-healthcare settings (22%), 57 tests were performed in CBOs and other service organizations (16%), 52 tests were performed in emergency room departments (15%), 36 tests were performed in other primary care clinics (10%), and 20 tests were performed in other public health clinics (6%).

Table 94: MDHHS funded HIV testing by test result and individual demographics, DMA, 2014

	No. HIV Tests Performed	% HIV Tests Performed	No. Positive Tests	% Positive Tests
DMA Total	43,546	100	358	0.8
Gender				
Female	21,922	50	41	0.2
Male	21,461	49	306	1.4
Transgender	163	< 1	11	6.7
Age				
0-12 years	9	< 1	0	0.0
13-19 years	4,303	10	19	0.4
20-29 years	17,904	41	185	1.0
30-39 years	8,802	20	67	0.8
40-49 years	6,272	14	42	0.7
50-59 years	4,671	11	37	0.8
60+ years	1,585	4	8	0.5
Race				
African American	33,567	77	303	0.9
White	7,789	18	47	0.6
Other^	1,002	2	7	0.7
Unknown	1,188	3	1	0.1

^Other race includes Arab, Asian, Native American, and Pacific Islander

Source: Michigan Department of Health and Human Services, Counseling, Referral, and Testing (CTR) Data, 2014

In 2014, Category A funded agencies accounted for 56% of HIV tests and Category B funded agencies accounted for 44% of tests in the DMA (Table 95). The percent positivity of tests in Category A funded agencies (1.1%) was higher than in Category B funded agencies (0.5%). Tests performed in healthcare settings accounted for 85% of all tests and had a percent positivity of 0.5%. Tests performed in non-healthcare settings accounted for 15% of tests and had a percent positivity of 2.5%. Agencies categorized as ‘other non-healthcare setting’ accounted for 5% of all tests performed but had the highest percent positivity (5.1%). Tests that occurred in ‘other healthcare settings’ accounted for less than 1% of all tests performed yet had the second highest percent positivity (3.5%). Tests performed at CBOs and other service organizations accounted for 10% of all tests and had a percent positivity of 1.2%. Tests performed in Emergency Departments accounted for 35% of all tests in the DMA in 2014 and had a percent positivity of 0.4%. Tests occurring in STI clinics accounted for 30% of all tests and had a percent positivity of 0.6%.

Table 95: MDHHS funded HIV testing by test result and agency demographics, DMA, 2014

	No. HIV Tests Performed	% HIV Tests Performed	No. Positive Tests	% Positive Tests
MI Total	43,546	100	358	0.8
Funding				
Category A	24,589	56	271	1.1
Category B	18,957	44	87	0.5
Setting				
Healthcare	37,216	85	201	0.5
Non-Healthcare	6,330	15	157	2.5
Type				
Other Non-healthcare Settings	2,118	5	109	5.1
Other Healthcare Settings	142	< 1	5	3.5
CBOs and Other Service Organizations	4,487	10	52	1.2
Other Public Health Clinics	2,027	5	20	1.0
Other Primary Care Clinics	5,154	12	36	0.7
STI Clinics	13,226	30	79	0.6
Emergency Departments	15,380	35	57	0.4
Community Health Centers	12	< 1	0	0.0
Substance Abuse Treatment Facilities	1,000	2	0	0.0
Source: Michigan Department of Health and Human Services, 2014				

6.1.3. NEW DIAGNOSES IN THE DMA

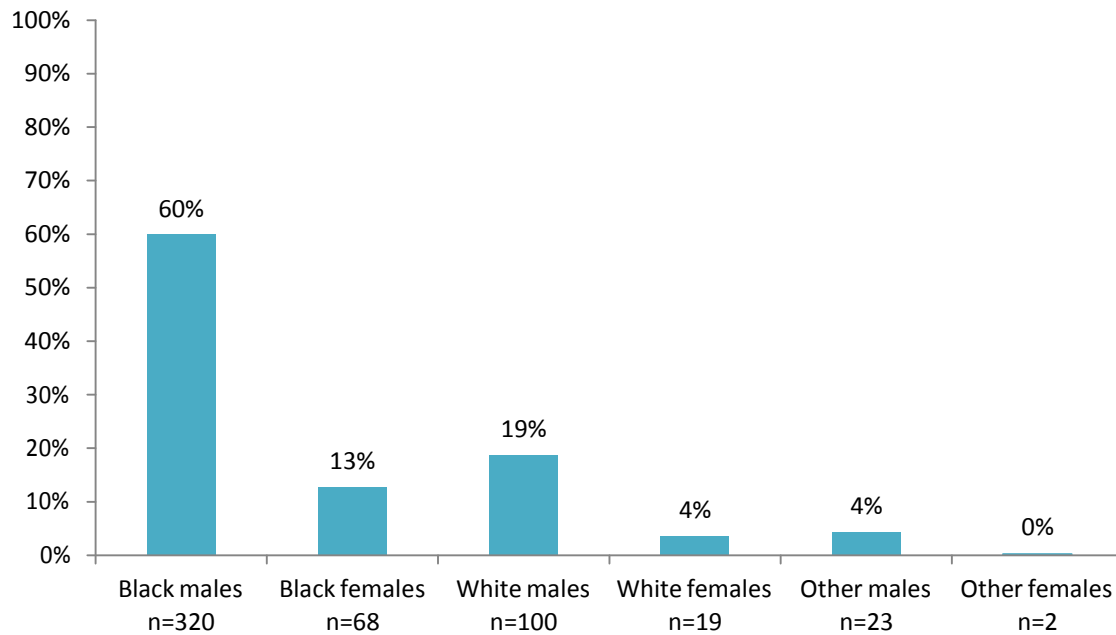
New diagnoses of HIV infection are the number of cases newly diagnosed over a given period of time, usually a year. New diagnoses do not necessarily represent new infections, as newly diagnosed cases may have been infected for many years and therefore, can include all stages of disease. An estimated number of new diagnoses, resulting from statistical adjustment that account for reporting delays and missing transmission category, are presented in this section. These estimates may not be representative of all persons with HIV because not all infected persons have been tested or tested at a time when the infection could be detected and diagnosed. In addition, testing patterns are influenced by many factors, including the extent to which testing is routinely offered to specific groups, or the availability of, and access to, medical care and testing services. The data presented in this section provide a minimum estimate of persons for whom HIV infection has been diagnosed and reported.

In 2013, the estimated rate of new diagnoses in the DMA was 12.5 per 100,000 population which is higher than the estimated rate of 8.1 per 100,000 in Michigan. Table 96 presents the distribution of estimated new diagnoses by gender, age, race, transmission category, and area in the DMA. The majority of new HIV diagnoses occurred in males (83%), African Americans (73%), men who had sexual contact with other men (56%), and the City of Detroit (52%). Individuals age 20 to 29 years and those age 30 to 39 years accounted for nearly 60% of new diagnoses in 2013. Figure 36 displays estimated new diagnoses by race and gender. Black males (60%) accounted for the most new diagnoses in 2013, followed by White males (19%), and Black females (13%).

Table 96: Distribution of estimated new HIV diagnoses by age, gender, race, and transmission Category, DMA, 2013

	N	%
Gender		
Males	444	83
Females	90	17
Age		
13-19	47	9
20-29	215	40
30-39	100	19
40-49	82	15
50-59	65	12
60+	25	5
Race		
Black	389	73
White	119	22
Other	26	5
Transmission Category		
MSM	299	56
IDU	17	3
MSM/IDU	6	1
Heterosexual Contact	89	17
Other Known	1	< 1
No Identified Risk	122	23
Area		
City of Detroit	278	52
Oakland	107	20
Out Wayne	84	16
Macomb	54	10
St. Clair	5	1
Monroe	3	1
Lapeer	2	< 1
DMA Total	534	100
Out Wayne=Wayne County excluding the City of Detroit		
Source: Michigan Department of Health & Human Services, <i>Annual Review of HIV Trends in Southeast Michigan (2009-2013)</i> ; Published April 2015.		

Figure 36: Estimated new diagnoses by race and gender, DMA, 2013



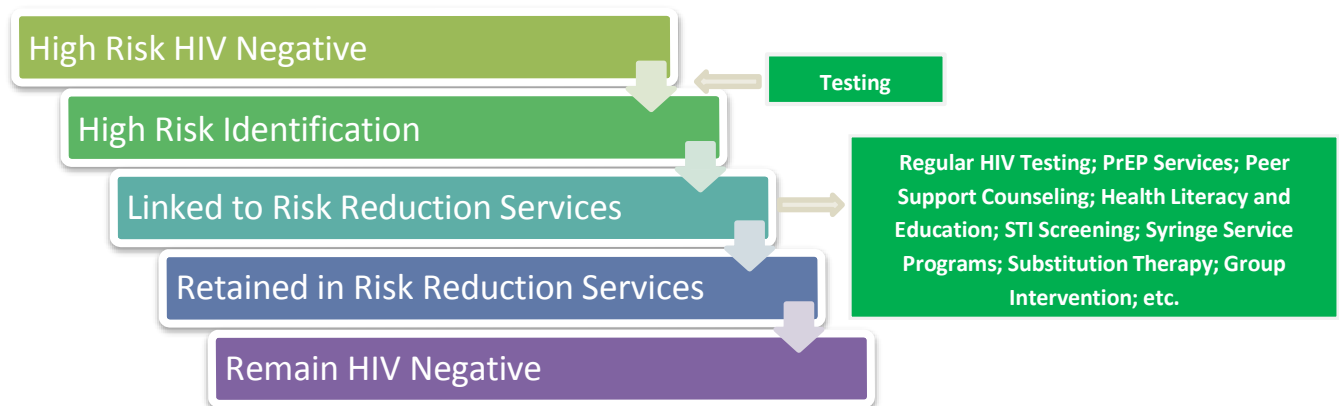
Source: Michigan Department of Health & Human Services, *Annual Review of HIV Trends in Southeast Michigan (2009-2013)*; Published April 2015.

Between 2009 and 2013, there was a statically significant decrease in cases among black females (7%). There were no other changes of new diagnosis among risk or age group or geography. The rate of new diagnosis in 2013 was highest in Detroit (40.4 per 100,000) and lowest in Monroe County (2.0). In Detroit the rate of new diagnosis was 39.9 per 100,000 persons in 2013.

6.1.4. THE PREVENTION CONTINUUM IN THE DMA

The HIV Care Continuum is a framework for understanding the status of engagement in HIV care and treatment and has been used by Federal, state, and local agencies to identify gaps in care and to develop strategies to improve engagement in care and outcomes of people living with HIV. Following the concept of the HIV Care Continuum a similar framework, the HIV Prevention Continuum, was created to help illustrate the series of stages a high risk, uninfected individual engages in from the initial identification of high risk behaviors through successful continuation of an HIV negative status. The HIV Prevention Continuum model has five stages including: uninfected individuals with high risk behaviors, the identification of individuals at high risk, linkage to risk reduction services, retention in risk reduction services, and continued HIV negative status (Figure 37). As part of the National HIV/AIDS strategy, recommended actions to prevent new HIV infections include targeting high risk populations, such as gay and bisexual men, African Americans, Latinos, and substance users, and ensuring that all HIV-negative people at high risk for HIV infection be tested for HIV and STIs annually and have access to behavioral and biomedical interventions and medical and social services with long term and sustainable outcomes that reduce the probability of HIV acquisition. Potentially, the HIV Prevention Continuum can be used to identify the proportion of individuals who are engaged at each stage and be used to identify issues and opportunities related to improving the delivery of these risk reduction services and reducing the number of new infections among high risk, uninfected individuals.

Figure 37: HIV prevention continuum for uninfected persons at high risk



A. Indicators of Risk

Direct measures of risk provide information about risk behaviors that are directly associated with HIV transmission. Indirect measures do not directly describe HIV risk behaviors but serve as indicators of possible HIV risk that may need further investigation. Some direct and indirect risk behaviors that indicate HIV risk include sexual activity and practices, number of sex partners, sexual orientation, substance use, and the presence of other sexually transmitted infections.

Self-reported risk factors of persons testing at Counseling, Testing, and Referral (CTR) sites in the DMA are present in Table 97. Although persons may have engaged in more than one risk behavior, having sex without a condom with a male or female partner (75%) and having sex while intoxicated and/or high on drugs (45%) were the most frequently reported risk behaviors. Three percent of persons reported injecting drugs and 3% of persons reported having sex with someone who injected drugs. Six percent of men reported having sex with another man and less than one percent of females reported having sex with a man who has sex with men. One percent of persons reported having sex with someone who was HIV positive.

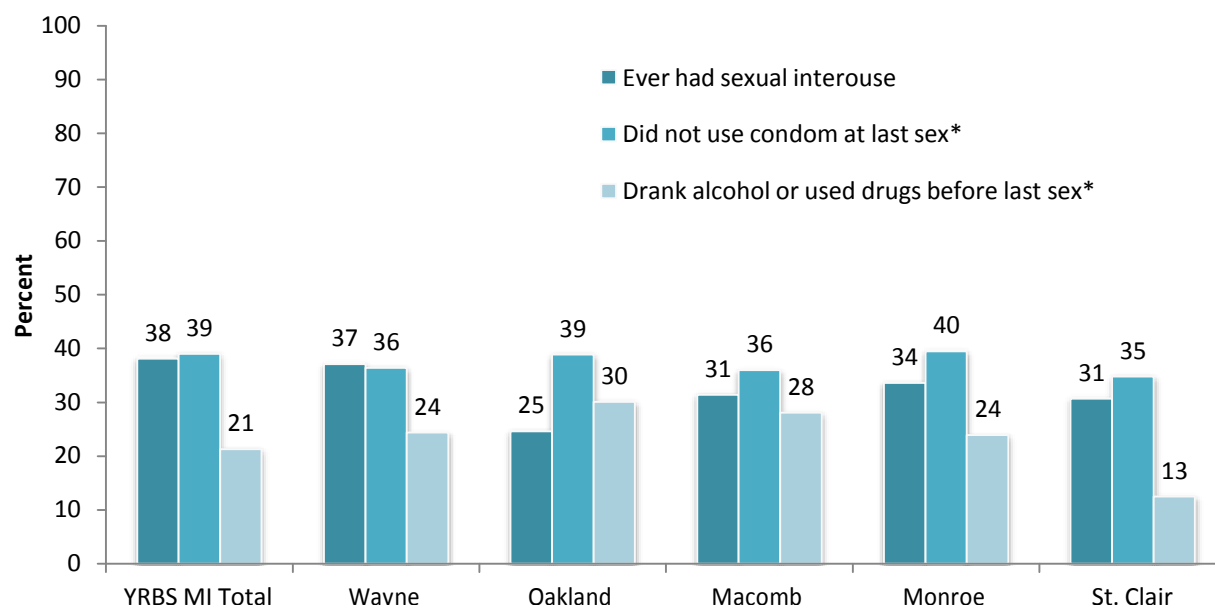
Table 97: HIV risk indicators among persons who tested at CTR sites in the DMA, 2014

	N	%
No condom use	32,835	75
Sex while intoxicated and/or high on drugs	19,420	45
MSM	2,553	6
Exchanged sex for money/drugs/something else	1,442	3
IDU	1,135	3
Sex with person who is IDU	743	2
Sex with person who is HIV+	562	1
Female who has sex with MSM	83	< 1
Total Test Events	43,546	
Note: Categories are not mutually exclusive as persons can engage in multiple risk behaviors		
Source: Michigan Department of Health and Human Services, 2014		

Among Michigan high school students surveyed in the Michigan Youth Behavior Survey, 38% reported having had sexual intercourse. Of Michigan students who reported having sexual intercourse in the previous three months, 39% reported not using a condom at last sexual intercourse and 21% reported drinking alcohol or using drugs before last sexual intercourse (Figure 38). County level data on sexual behavior is published by the Michigan Profile for Healthy Youth (MiPHY). Among counties in the DMA, a greater percentage of students in Wayne County (37%) reported ever having sexual intercourse compared to Monroe (34%), St. Clair (31%), Macomb (31%), and Oakland (25%). Of high school students who had sexual intercourse in the previous 3 months, 40% of students in Monroe County and 39% of students in Oakland County did not use a condom at last sexual intercourse. The percentage of students

who reported drinking alcohol or using drugs before their last sexual intercourse ranged from 30% in Oakland County to 13% in St. Clair County. Data for Lapeer County were not available.

Figure 38: Did not use condom* among high school students, Michigan and the DMA[^], 2013-2014



[^]Data for Lapeer County was unavailable

*Among students who had sexual intercourse during the past three months

Source: Michigan Department of Education, MiPHY Regional Demographics Summary, 2013-2014

Injection drug use and substance abuse are risk factors for HIV transmission. Additionally, persons using illicit drugs and consuming large amounts of alcohol are at risk due to impaired judgment that may increase the chances of engaging in risky behaviors. The National Survey on Drug Use and Health (NSDUH) estimates that 17% of persons 12 years and older in the City of Detroit use illicit drugs, which was substantially higher than the overall rate in Michigan and in other areas in the DMA (Table 98). When marijuana use was excluded, illicit drug use in the City of Detroit decreased to around 4%, which was comparable to the average use in Michigan and other areas in the DMA. Binge alcohol use, which is defined as drinking five or more drinks at the same time or within a couple hours of each other, was seen the highest in Macomb County (26%), followed by Oakland County (25%), and the Southeast region of the DMA (25%), which is Monroe County and Wayne County excluding the City of Detroit. An estimated 10% of persons 12 years and older in Detroit have a dependence on illicit drugs or alcohol and 7% and 4% of persons living in Detroit needed treatment for illicit drug use and/or alcohol use but did not receive it. An estimated 9% of persons 12 years and older living in Macomb County have a

dependence on illicit drugs or alcohol and 8% and 2% of persons needed treatment for drug use and/or alcohol use but did not receive it.

Table 98: Estimates of illicit drug use and alcohol use among persons 12 years and older by region, DMA, 2010-2012

	Illicit drug use*	Illicit drug use other than marijuana*	Binge alcohol use*	Dependence or abuse of illicit drugs or alcohol^	Needing but not receiving treatment for illicit drug use^	Needing but not receiving treatment for alcohol use^
	%	%	%	%	%	%
City of Detroit	17.0	3.7	21.0	10.0	6.5	4.4
Macomb	9.3	3.2	26.4	9.0	7.5	2.0
Oakland	9.6	3.2	24.8	8.4	6.6	2.2
Southeast ¹	10.9	3.8	24.6	8.4	6.5	2.5
St. Clair	9.4	3.7	22.8	7.9	5.8	2.1
Michigan	10.8	3.6	25.2	8.7	6.7	2.4

*in past month

^in past year

¹Southeast includes Monroe and Wayne counties excluding the City of Detroit

Illicit drug use includes marijuana, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used non-medically; Binge alcohol use is defined as drinking five or more drinks on the same occasion (i.e., at the same time or within a couple of hours of each other) on at least 1 day in the past 30 days; Dependence or abuse is based on definitions found in the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV).

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2010, 2011, and 2012

Sexually transmitted infection (STI) data are indirect indicators of HIV risk as they may serve as a surrogate marker for unsafe sexual practices in a specific population. Individuals who are infected with STIs are more likely than uninfected individuals to acquire HIV infection if they are exposed to the virus through sexual contact. In addition, HIV infected individuals also infected with another STI are more likely to transmit HIV through sexual contact than other HIV infected persons.

In the DMA, Wayne County has the highest rates of STI infection (Table 99). The rate of infection for chlamydia (885.4 per 100,000), gonorrhea (281.3 per 100,000), and syphilis (33.0 per 100,000) in Wayne County is substantially higher than the overall rate in Michigan and that of other counties in the DMA.

Table 99: Rates of sexually transmitted infections by region, DMA, 2013

	Chlamydia	Gonorrhea	Syphilis (all stages)	Primary & Secondary Syphilis
Wayne	885.4	281.3	33.0	16.4
Oakland	299.2	70.6	13.2	5.8
Macomb	248.7	67.6	9.2	**
Michigan	455.7	106.6	10.9	5.0
Rate per 100,000				
Source: Michigan Sexually Transmitted Infections Database, Michigan Department of Health and Human Services				

In 2013, the Detroit Health Department contributed 44% of statewide primary and secondary syphilis cases. Of Detroit's 2013 primary and secondary syphilis cases, 157 are men who have sex with men and 68% of those MSM are HIV+. Of the 157 MSM, 55% have more than 2 partners in the last year and 29% report anonymous partners and 35% report internet partners.

B. HIV Transmission Category

HIV Transmission categories were created for summarizing the multiple risk factors that a person may have had by selecting the one most likely to have resulted in HIV transmission. For surveillance purposes, persons with more than one reported risk factor for HIV infection are classified in the transmission category listed first in a hierarchy of transmission categories, and therefore counted once. The exception is men who have sexual contact with other men and injected drugs; this group makes up a separate transmission category.

Table 100 presents the mode of HIV transmission by gender and race/ethnicity for the DMA. Among males, the most common mode of HIV transmission was through male to male sex (68%). This trend was similar for each race/ethnicity group. However, compared to White males, a greater percentage of Black men and Hispanic men contracted HIV infection through injection drug use and through undetermined modes of transmission. Among females, the most common mode of HIV transmission was through heterosexual contact (64%). This trend was fairly similar for each race/ethnicity group.

Table 100: Mode of HIV transmission by gender and race/ethnicity, DMA, 2014

	White		Black		Hispanic		Other/ Unknown N		Total	
	N	%	N	%	N	%			N	%
Males										
Total	2,405	30	5,177	64	285	4	246	3	8,113	100
Male-Male Sex	1,863	77	3,400	66	192	67	163	66	5,618	69
IDU	82	3	326	6	18	6	12	5	438	5
MSM/IDU	117	5	182	4	3	**	17	7	319	4
Blood Products	26	1	5	<1	1	**	1	**	33	<1
HCFR	68	3	284	5	19	7	5	2	376	5
Perinatal	6	<1	53	1	3	**	6	2	68	1
Undetermined	243	10	927	18	49	17	42	17	1,261	16
Females										
Total	307	13	1914	81	74	3	68	3	2,363	100
IDU	58	19	295	15	14	19	12	18	379	16
Blood Products	4	**	2	**	1	**	0	0	7	<1
HCM	202	66	1,244	65	50	68	41	60	1,537	65
Perinatal	4	**	42	2	2	**	3	**	51	2
Undetermined	39	13	331	17	7	9	12	18	389	16

IDU=Injection drug use; MSM=Male to Male Sex; HCM=Heterosexual contact with male (females who have had sex with a male regardless of what is known about the male's HIV status or behaviors; HCFR=Heterosexual Contact with Female Risk (males whose female sexual partners are known to be HIV-infected or at high risk for HIV. These partners meet one of the following criteria: IDU, hemophiliac, HIV infected transfusion recipient, or other HIV infected person of unknown risk).

Source: Michigan Department of Health and Human Services, *Annual HIV Surveillance Report, Southeast Michigan*; Published July 2015

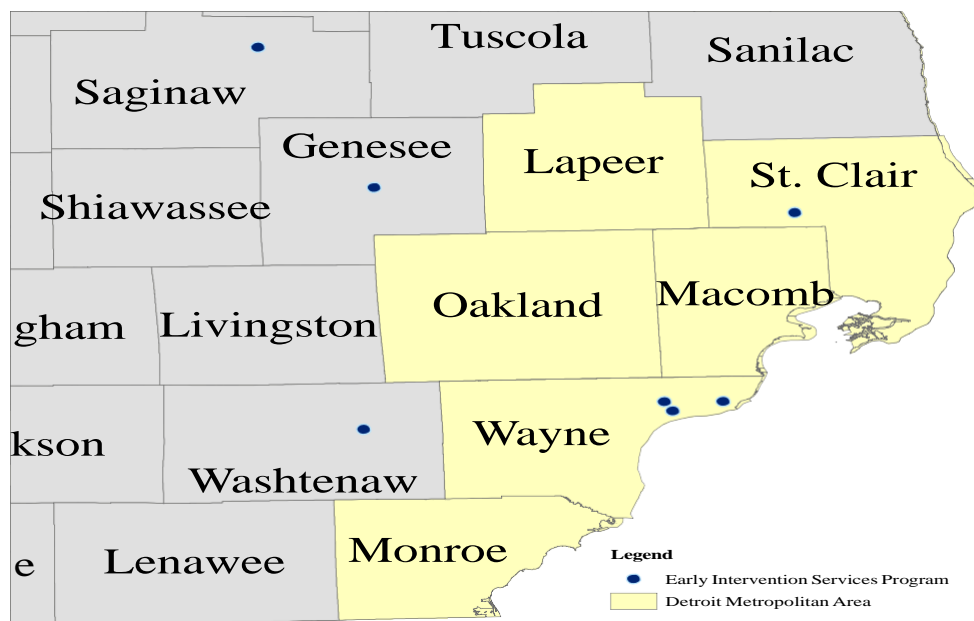
C. HIV Early Intervention Services in the DMA

HIV Early Intervention Services (EIS) is a program funded through the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA). EIS was established to support the incorporation of HIV prevention into the medical care of persons living with HIV and was created to prevent new HIV infections, increase the proportion of persons with HIV who are aware of their infection, prevent HIV-related illness and death, and reduce HIV-related health disparities. The program consists of biomedical, behavioral, and structural interventions that can help reduce the risk of HIV transmission from persons with HIV by reducing their infectiousness and their risk of exposing others to HIV. In order for an individual to be eligible for these services, an individual must meet the following criteria: 1). HIV-positive, 2). resident of Michigan, 3). income level that does not exceed 450% of the Federal Poverty Level, and 4). underinsured or uninsured for applicable Ryan White services that are reimbursable through third party payers.

Services within the program include counseling, testing, referral, and information assistance designed to bring HIV-positive individuals into the local HIV continuum of care. These services can be provided at

public health departments, emergency rooms, substance abuse and mental health treatment programs, detoxification centers, detention facilities, STI clinics, homeless shelters, and HIV/AIDS counseling and testing sites. As of February 2015, there were 13 organizations that provided EIS services in Michigan, with four of these organizations providing services directly in the DMA: Detroit Community Health Connection; Sacred Heart Rehabilitation Center, Inc., Bay Area Social Intervention Services (BASIC); Voices of Detroit Initiative; and Wayne State University (Figure 39).

Figure 39: HIV Early Intervention Services, DMA

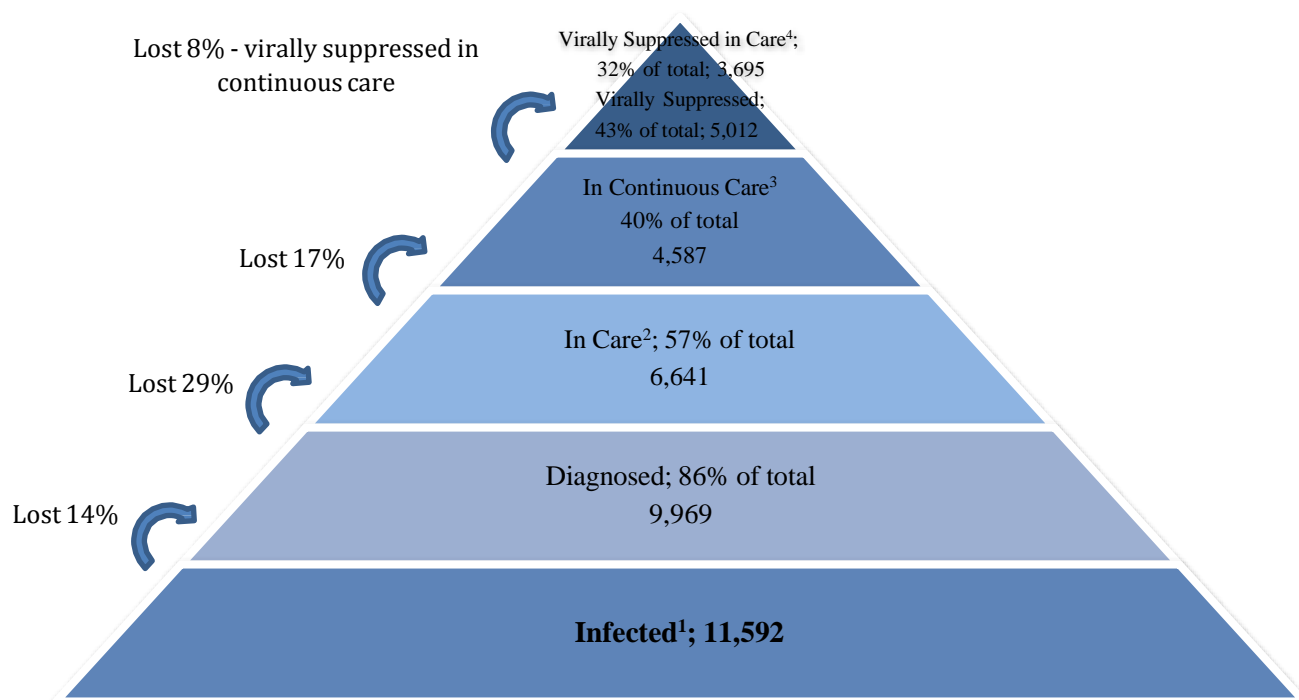


Michigan Department of Health and Human Services and Ryan White Part C Funded Early Intervention Services Providers, as of 02/06/2015

6.1.5. THE CARE CONTINUUM IN THE DMA

The HIV Care Continuum is a model that outlines the sequential stages of HIV medical care that people living with HIV go through from initial diagnosis to achieving the goal of viral suppression. The HIV Care Continuum has five stages and is used to show the proportion of individuals living with HIV who are engaged in each stage. The five stages include: those aware and unaware of their HIV infection, HIV diagnosis, linkage to care, retention in care, and viral suppression. The prevalence-based model shows each step of the continuum as a percentage of the total number of people living with HIV. This approach was used so that the care continuum for all people living with HIV in Michigan can be examined. This method allows for monitoring of broad populations, such as African Americans or men who have sex with men, overall. The HIV Care Continuum for the DMA is presented in Figure 40.

Figure 40: HIV Care Continuum, DMA, 2013



¹Persons aware and unaware of their infection; based on National estimate that 14% of PLWHA are unaware of their infection.; ²In care: PLWH with at least one CD4, viral load (VL), and /or genotype lab test during the given year

³In continuous care: PLWH who received at least two CD4, viral load (VL), and/or genotype lab tests with the given year at least three months apart; ⁴Virally suppressed in care: PLWH in continuous care whose most recent viral load test had less than or equal to 200 copies of HIV virus per milliliter of blood; 1,953 persons were virally suppressed but not in continuous care during the year; gained 3% virally suppressed

Source: Michigan Department of Health and Human Services and Human Services, *Metropolitan Statistical Area (DMA) HIV Care Continuum, January 2015*.

A. Unaware

In 2013, approximately 14% of the estimated 11,592 people living with HIV infection in the DMA were undiagnosed. This is a broad CDC estimate applied to Michigan statistics. Late HIV Diagnosis, or concurrent diagnosis, is diagnosis with both HIV infection and Stage 3 (AIDS) infection within 30 days. This diagnosis is likely to occur in people who have been infected for some time prior to learning of their status and are therefore late to access HIV-related care and support. These individuals represent a population who are unaware of their HIV infection and may not experience the full benefits of these services, including improved health, better quality of life, longer survival, and reduction in the likelihood of transmitting HIV to others. In the DMA, of the estimated 534 newly diagnosed cases of HIV infection in 2013, approximately 25% were diagnosed at Stage 3 (AIDS) (Table 101). A greater percentage of men (25%) were diagnosed at a later stage than women (22%) and Whites (29%) and persons of other racial groups (27%) were more likely than Blacks (23%) to be diagnosed at a later stage.

Table 101: Late HIV diagnosis, DMA, 2013

	Stage 3 (AIDS) Diagnosis within 30 Days of Diagnosis	Persons Newly Diagnosed	Late HIV Diagnosis
All	131	534	25%
Gender			
Male	111	444	25%
Female	20	90	22%
Race			
White	35	119	29%
Black	90	389	23%
Other	7	26	27%

Source: Michigan Department of Health & Human Services, *Annual Review of HIV Trends in Southeast Michigan (2009-2013)*; Published April 2015

B. HIV Medical Care: Linkage and Retention

In 2013, of the estimated 9,969 people diagnosed with HIV infection in the DMA, approximately 29% were not linked to any HIV medical care. An analysis of Ryan White Part A patient data from 2013, shows that of the 396 individuals who tested positive for HIV, 58 (15%) were never linked to care (Table 102). Men who have sex with men and inject drugs (MSM/IDU), injection drug users (IDU), and persons age 19 to 29 years were less likely to be linked to care compared to other population groups. It is important to note that because the Ryan White HIV/AIDS Program provides HIV-related services for those who do not have sufficient health care coverage or financial resources, this data does provide information for monitoring access to HIV care services in disadvantaged populations but it is not representative of the population as a whole.

Table 102: Linkage to HIV medical care among Ryan White Part A patients living with HIV/AIDS, DMA, 2013

Demographic Category	Persons diagnosed*	Persons linked to care in 3 months			to hs		Persons ever linked to care		Pe li Persons never linked to care
	N	N	%	N	%	N	%	N	
Gender									
Female	61	58	95	0	0	58	95	3	
Male	333	274	82	5	2	279	84	54	
Transgender	2	1	50	0	0	1	50	1	
Risk									
MSM	243	204	84	5	2	209	86	34	
IDU	10	8	80	0	0	8	80	2	
MSM/IDU	5	3	60	0	0	3	60	2	
Heterosexual	64	59	92	0	0	59	92	5	
Age at diagnosis									
13 - 18 years	16	15	94	0	0	15	94	1	
19 - 24 years	128	99	77	3	2	102	80	26	
25 - 29 years	68	53	78	1	1	54	79	14	
30 - 34 years	40	37	93	0	0	37	93	3	
35 - 39 years	26	24	92	0	0	24	92	2	
40 - 49 years	63	55	87	0	0	55	87	8	
50 - 59 years	44	40	91	1	2	41	93	3	
60+ years	11	10	91	0	0	10	91	1	
Total	396	333	84	5	1	338	85	58	

*Newly diagnosed positive HIV tests between 1/1/13 - 12/31/13

Source: Michigan Department of Health and Human Services, Ryan White Part A Early Identification of Individuals with HIV/AIDS Data Request

Of the estimated 6,641 persons who were linked to care in the DMA, 17% were not retained in HIV medical care in 2013. The need for HIV related health services by individuals with HIV who are aware of their HIV status, but are not receiving regular primary care is defined as unmet need by the Health Resources and Services Administration (HRSA). Analysis for unmet need for medical services among people living with HIV/AIDS in the DMA was conducted in 2014 by the Michigan Department of Health and Human Services (MDHHS) during the 12-month time period of January 1, 2013 to December 31, 2013. Of persons living with HIV in the DMA, approximately 33% had an unmet need, which means that they did not have a medical visit which included a CD4 count and/or percent or a viral load measure during the 12-month period. Table 103 presents unmet need by population characteristics. Hispanic females (51%) and males (43%), injection drug users (40%), persons with undetermined risk (36%), persons age 60 years and older (36%) and residents of Monroe County (47%) had the greatest unmet need in the DMA.

Table 103: Unmet need by population characteristics, DMA, 2013

Population Characteristic	Unmet Need %	Population Characteristic	Unmet Need %
Race/Ethnicity and Gender		Region	
White Male	34	Lapeer	32
Black Male	32	Macomb	30
Hispanic Male	43	Monroe	47
Other Male	31	Oakland	33
White Female	36	St. Clair	33
Black Female	30	Wayne County	33
Hispanic Female	51	Wayne County excl. Detroit	31
Other Female	22	Detroit	33
Current Age (years)		Transmission Category	
0-12	22	MSM	32
13-19	27	IDU	40
20-29	32	MSM/IDU	31
30-39	33	Blood Recipient/Perinatal	29
40-49	33	HC	28
50-59	30	Undetermined	36
60+ years	36		

Note: Unmet need is defined as not having a laboratory result for a CD4 count and/or percent or a VL measure during a 12-month time period (January 1, 2013 through December 31, 2013)

Highlighted numbers signify top five responses in category

Source: Michigan Department of Health and Human Services. Detroit EMA Unmet Need Estimate and Assessment FY2015

C. Viral Suppression

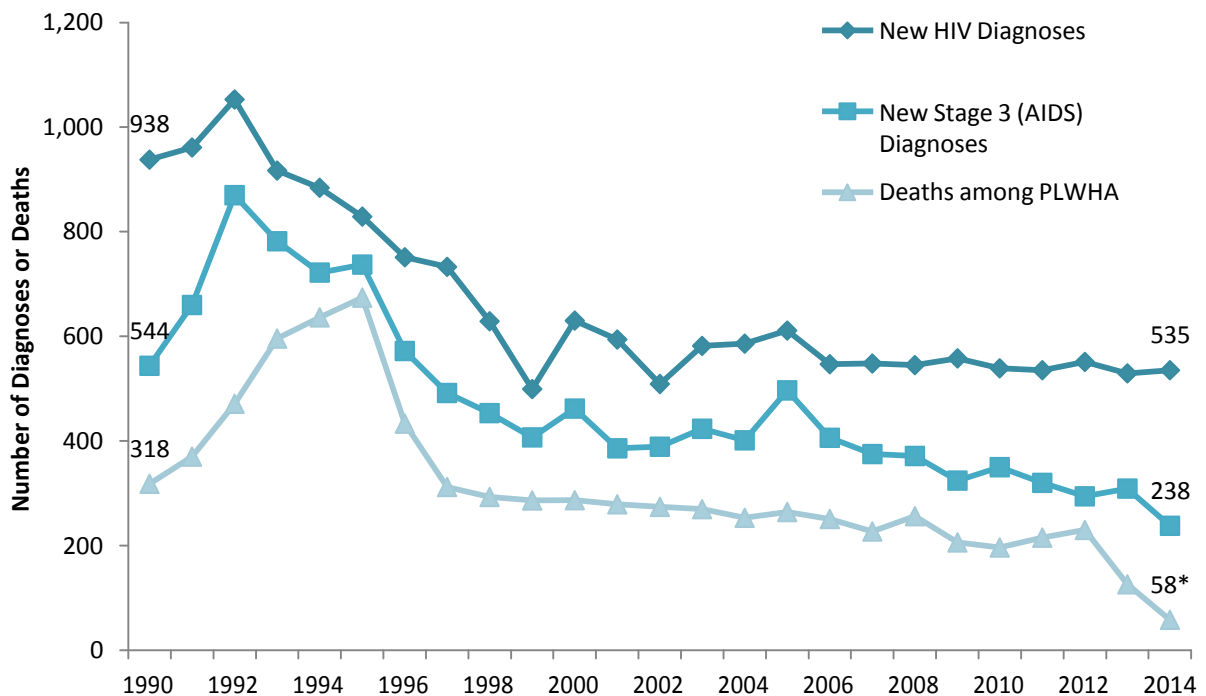
Achieving viral suppression is defined as having an HIV viral load of less than 200 copies/mL at last test. Suppressed levels of the HIV virus allow people living with HIV to live longer and healthier lives and decreases the likelihood of transmitting HIV to others. Of the estimated 11,592 people living with HIV (diagnosed and undiagnosed) in the DMA, in 2013, only 30% to 40% achieved viral suppression. This is due to persons with HIV not being diagnosed, not being linked to HIV medical care, and not taking HIV medications. Of individuals in HIV medical care, over 80% achieve viral suppression.

Of those with diagnosed HIV infection, approximately 50% of individuals in the DMA achieve viral suppression which is comparable to the overall percentage in Michigan. Only 33% of HIV positive persons residing in the Benton Harbor MSA had achieved viral suppression.

6.1.6. TRENDS IN THE HIV/AIDS EPIDEMIC IN THE DMA

The number of reported cases of HIV and AIDS in the DMA has declined significantly since 1990 (Figure 41). Since 1990, new diagnoses of HIV infection have decreased by 43%. Diagnoses of Stage 3 (AIDS) HIV infection peaked in 1992 and have declined by 73%. In the last 5 years, the number of new HIV diagnoses has declined by 4% and the number of Stage 3 (AIDS) diagnoses declined by 27%. The number of deaths of HIV infected persons peaked in 1995, saw a sharp decline, and has slowly declined since 2000.

Figure 41: Trends in HIV/AIDS diagnoses and deaths, DMA, 1990-2013

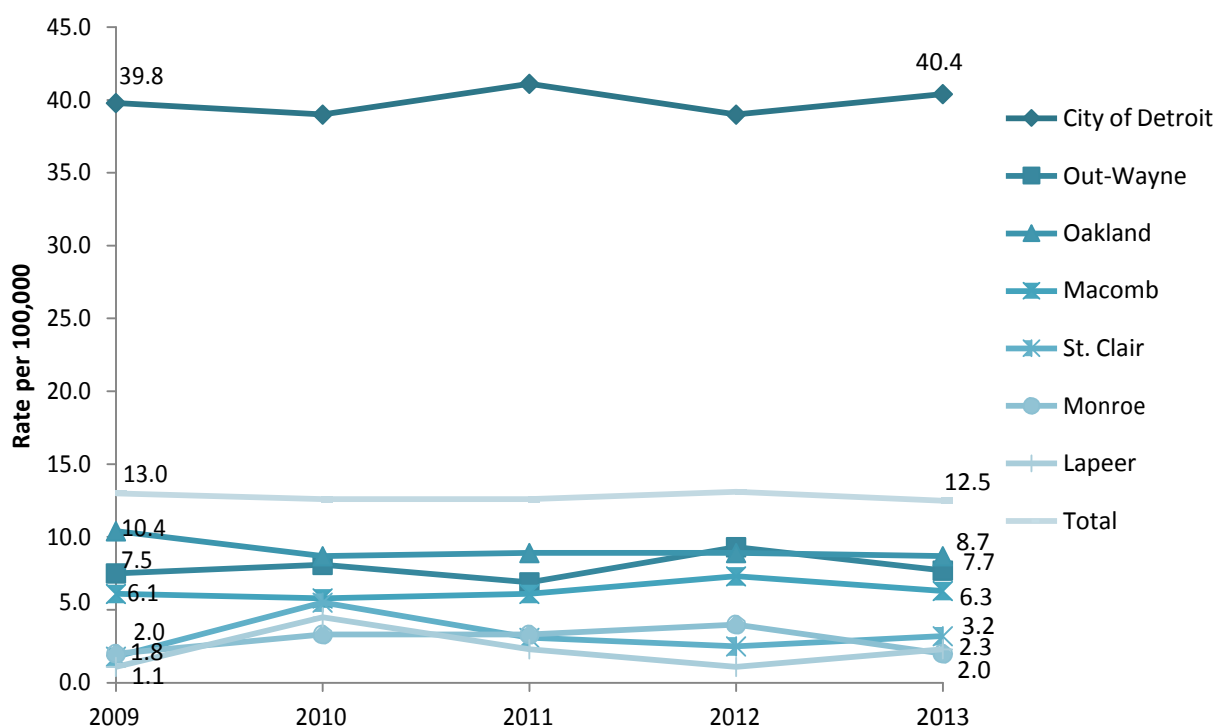


**Reported deaths for most recent years may not be complete

Source: Michigan Department of Health and Human Services, *Annual HIV Surveillance Report, Southeast Michigan*; Published July 2014

Since 2009, the rate of new HIV diagnoses in the DMA remained stable and is 12.5 per 100,000, which is greater than Michigan's rate of 8.1 per 100,000. The rate of new HIV diagnoses in the City of Detroit, which is substantially higher than any other rate in Michigan, did not change drastically since 2009 and is currently at 40.4 per 100,000 (Figure 42). The rate of new diagnoses remained fairly constant in Wayne County excluding the City of Detroit (Out Wayne) and in Macomb and Monroe counties. New diagnoses rates have slightly increased in Lapeer and St. Clair counties since 2009, while the rate of new diagnoses decreased in Oakland County by 16%.

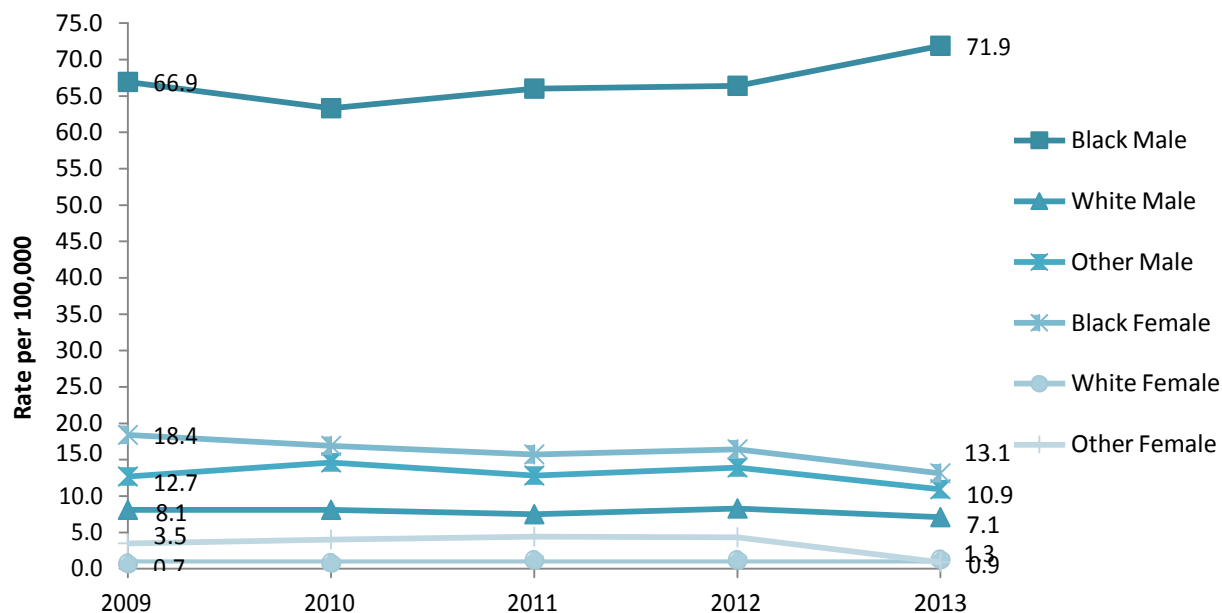
Figure 42: New diagnoses by region, DMA, 2009-2013



Source: Michigan Department of Health and Human Services, Annual Review of HIV Trends in Southeast Michigan (2009-2013); Published April 2015

The rate of new HIV diagnosis among African American males, which is the highest among any other race/gender group, increased from 66.9 per 100,000 in 2009 to 71.9 per 100,000 in 2013 (Figure 43). The rate among African American females, which is the second highest rate, decreased from 18.4 per 100,000 in 2009 to 13.1 per 100,000 in 2013. Rate decreases also occurred among White males and among men and women of other racial groups. White women, who historically have had the lowest rate of new HIV diagnosis, increased from 0.7 per 100,000 in 2009 to 1.3 per 100,000 in 2013.

Figure 43: New diagnoses by race and gender, DMA, 2009-2013



Source: Michigan Department of Health and Human Services, Annual Review of HIV Trends in Southeast Michigan (2009-2013); Published April 2015

As seen in figure 44, persons 20 to 29 years of age have the highest rate of new HIV diagnosis (39.9 per 100,000), a rate that has increased since 2009 (38.8 per 100,000). The rate of new diagnoses among persons age 60 years and older increased from 1.5 per 100,000 in 2009 to 2.8 per 100,000 in 2013. The rate of new diagnoses among 30 to 39 year olds did not change markedly since 2009. The rate of new HIV diagnoses among all other age groups declined.

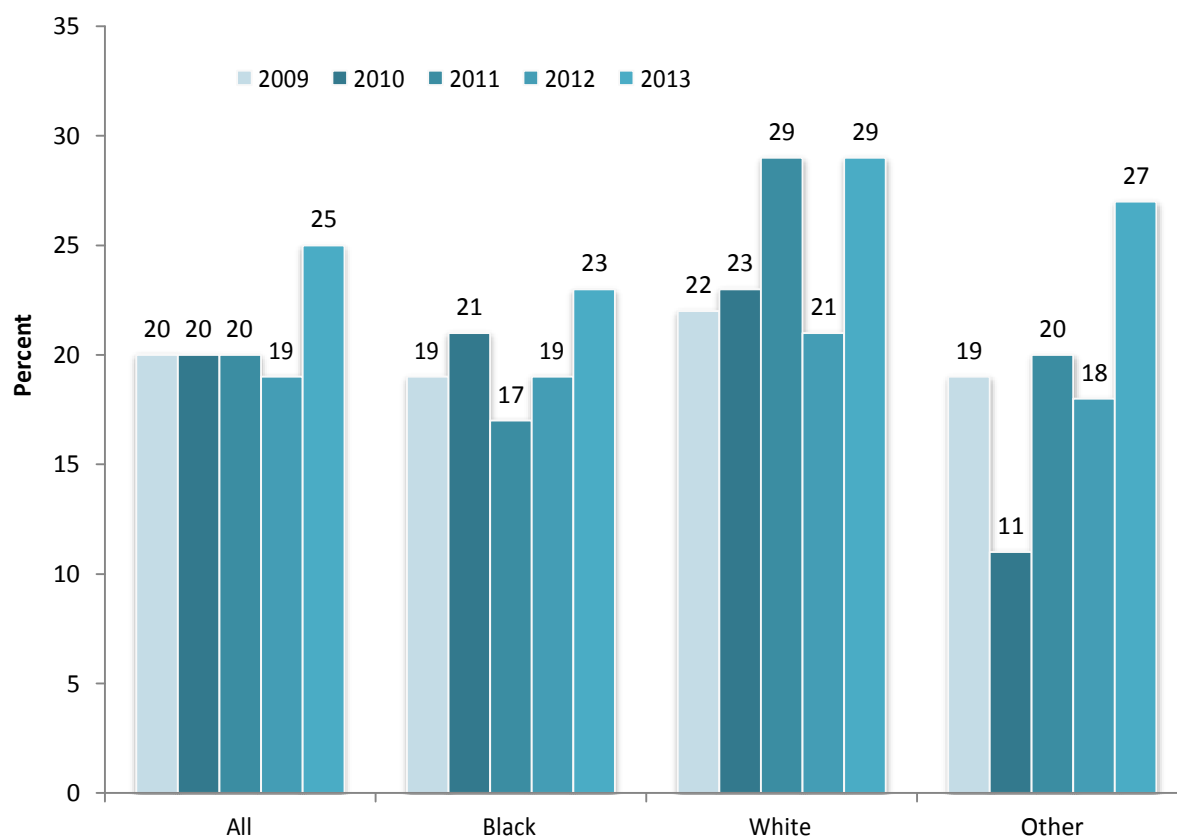
Figure 44: New diagnoses by age, DMA, 2009-2013



Source: Michigan Department of Health and Human Services, Annual Review of HIV Trends in Southeast Michigan (2009-2013); Published April 2015

Concurrent diagnosis, diagnosis with both HIV infection and Stage 3 (AIDS) infection within 30 days, is likely to occur in people who have been infected for some time prior to learning of their status and are therefore late to access HIV-related care and support. These individuals represent a population who are unaware of their HIV infection and may not experience the full benefits of these services, including improved health, better quality of life, longer survival, and reduction in the likelihood of transmitting HIV to others. Overall, the proportion of persons diagnosed with Stage 3 (AIDS) within 30 days of diagnosis increased from 20% in 2009 to 25% in 2013 (Figure 45).

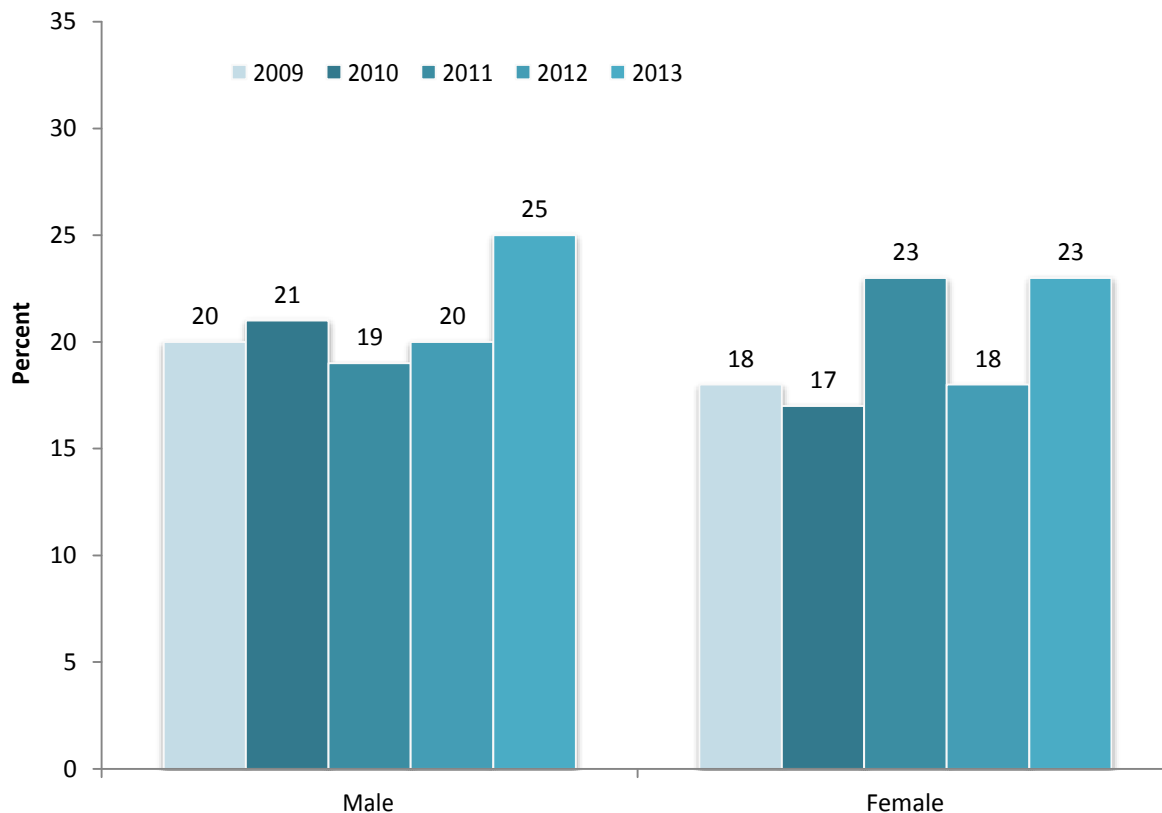
Figure 45: Concurrent diagnosis by race, DMA, 2009-2013



Source: Michigan Department of Health and Human Services, Annual Review of HIV Trends in Southeast Michigan (2009-2013); Published April 2015

Even though concurrent diagnosis increased for each racial group, in 2013, whites and persons of other racial groups have the highest proportion of concurrent diagnosis. Since 2009, the proportion of concurrent diagnosis increased for both men and women. In 2013, 25% of men and 23% of women had a concurrent diagnosis (Figure 46).

Figure 46: Concurrent diagnosis by gender, DMA, 2009-2013



Source: Michigan Department of Health and Human Services, Annual Review of HIV Trends in Southeast Michigan (2009-2013); Published April 2015

SECTION 6.1 SUMMARY: EPIDEMIOLOGIC OVERVIEW OF HIV INFECTION IN DETROIT METROPOLITAN AREA (DMA)

- In 2014, there were an estimated 10,476 persons living with HIV in the DMA. Wayne County had the greatest number of HIV cases and the highest rate of persons living with HIV in Michigan. The City of Detroit accounted for 78% of HIV cases in Wayne County, which was a rate of 800 cases per 100,000 population.
- Black/African American residents were disproportionately impacted by HIV. Black males accounted for the greatest number of HIV cases, with a rate of 1,168 cases per 100,000 population. Black females accounted for the second highest number of HIV cases, with a rate of 368 cases per 100,000 population.
- In 2014, 43,546 tests were performed at MDHHS designated testing sites in the DMA. The majority of tests were among African Americans and individuals aged 20 to 29 years. Of the tests performed, 99% were negative and less than 1% were positive. Category A provides funding for HIV prevention programs for health departments. Category A funded agencies accounted for 56% of all tests and had a percent positivity of 1.1%. Category B provides funding for expanded HIV testing for disproportionately affected populations. Category B funded agencies accounted for 44% of all tests and had a percent positivity of 0.5%.
- There were an estimated 534 new diagnoses of HIV in Michigan in 2013. Of those newly diagnosed, the majority were male, Black, and men who have sex with men. Forty percent of newly diagnosed were 20 to 29 years old and 53% resided in the City of Detroit.
- Male to male sexual contact is the leading mode of transmission for HIV among males, followed by undetermined modes and injecting drug use. Heterosexual contact is the leading mode of transmission for HIV among women, followed by injecting drug use and undetermined modes of transmission.
- In 2014, an estimated 33% of persons living with HIV in the DMA had an unmet need. A greater percentage of Hispanics, injection drug users, persons with undetermined risk, persons age 60 years and older, and residents of Monroe County had unmet need compared to other population groups.
- The rate of new diagnoses in the DMA has remained stable since 2009 and was 12.5 cases per 100,000 in 2013. Rates of new HIV diagnoses have increased among Black males and white females. Decreased rates were seen among Black females, white males, and men and women of other racial groups.
- Overall, the proportion of persons with concurrent diagnoses increased from 20% in 2009 to 25% in 2013. In 2013, Whites and persons in other racial groups had the highest proportion of concurrent diagnoses.

6.2. PRIMARY DATA COLLECTION AMONG PERSONS LIVING WITH HIV/AIDS IN THE DMA

As the first phase of the Themes and Strengths portion of the MAPP assessment (see Section 1.1 Needs Assessment Process), a statewide, in-person survey was administered among persons living with HIV/AIDS. The purpose of this survey was to supplement and address gaps in existing secondary data within the state. An original survey, consisting of both multiple choice and open-ended questions, was developed by MPHI with feedback from members of the Themes and Strengths and Steering Committees. Survey topics included HIV testing and diagnosis, partner services, initial linkage to medical care and care services, initial linkage to a case manager and support services, current use of medical care and support services, HIV medications, viral suppression, services needed, PrEP knowledge and attitudes, and suggestions for service improvement. This survey is not representative of the DMA and does not include information on clients from St. Clair or Lapeer. Data from this survey should be used in addition to other secondary data sources. A copy of the survey tool can be found in the Appendix.

The counties for recruitment were selected based on the prevalence of HIV infection, the proportion of unmet need and the proportion of the population who are virally suppressed. Participants were recruited from local health departments, HIV/AIDS service organizations (ASOs), community based organizations (CBOs), HIV/AIDS support groups, testing facilities, Ryan White providers, bars and social settings as referred by members of the Steering and Subcommittee members. Organizations were asked to target recruitment efforts to persons living with HIV from specific groups (e.g., young black men who have sex with men, transgender individuals, injecting drug users, individuals who were recently out of care, etc.). Several organizations and support groups were chosen as recruitment locations because their primary client population represented one of our targeted groups.

Surveys were administered during July and August in a private location by trained interviewers or self-administered if a participant preferred to do so. The consent process and survey administration took anywhere from 45 minutes to 1 hour and respondents were provided a \$20 Visa gift card for their time. Data from multiple choice questions were analyzed using the Statistical Package for the Social Sciences (SPSS) and are presented using descriptive statistics. Surveys were not audio-recorded, thus all answers to open-ended questions consisted of notes written by interviewers or participants with few verbatim, direct quotes. Data from open ended questions were coded and organized into themes. Responses under each theme were enumerated and themes were presented in rank order.

The research protocol, informed consent script, and survey tool were approved by the Institutional Review Board (IRB) at the Michigan Public Health Institute in Okemos, Michigan and the Michigan Department of Health and Human Services IRB in Lansing, Michigan.

Trained survey administrators traveled to recruitment sites throughout the state, administering a total of 191 surveys with participants representing 21 Michigan counties. 107, or 56%, of these surveys were collected from counties within the DMA with participants from Wayne, Oakland, and Macomb counties. Figure 47 presents the counties in which primary data was collected among PLWH. Throughout this section, data will be presented both for the DMA and for the state of Michigan as a whole, for comparative purposes; only data from the DMA will be discussed in text.

A map of Michigan counties with the following labels: W, Genesee, Lapeer, St. Clair, ee, Macomb, Oakland, ngston, itenaw, Wayne, ee, and Monroe. The map uses a color-coded legend to indicate survey completion status.

County	Survey Status
Genesee	Surveys completed among PLWH*
Lapeer	No surveys completed
St. Clair	No surveys completed
Macomb	Surveys completed among PLWH*
Oakland	Surveys completed among PLWH*
ngston	Surveys completed among PLWH*
itenaw	Surveys completed among PLWH*
Wayne	Surveys completed among PLWH*
Monroe	No surveys completed

*County of residence

Table 104 presents the demographics of PLWH surveyed, including age, gender, race, ethnicity, and sexual identity. More than half of those surveyed in the DMA were between the ages of 18-35 (56%), and a vast majority were male (76%). Over half of participants were black/African American (58%).

Table 104: Demographics among persons living with HIV/AIDS, DMA, 2015

Characteristic	Michigan		DMA	
	n (n=191)**	%	n (n=107)**	%
Age (years)				
18-25	29	16	24	23
26-35	47	26	35	33
36-45	35	19	21	20
46-55	42	23	10	9
56+	31	17	16	15
Gender				
Male	133	72	81	76
Female	47	25	22	21
Transgender	4	2	3	3
Genderqueer	1	1	1	1
Race				
Black/African American	92	51	61	58
White	70	38	28	26
Multiracial	10	5	9	8
Other^	6	3	5	5
American Indian/Alaska Native	3	2	2	2
Asian	1	1	1	1
Ethnicity				
Not Applicable	118	67	60	60
Other*	30	17	17	17
Hispanic/Latino	12	7	9	9
Unknown	11	6	9	9
Arab/Chaldean	5	3	5	5
Sexual Identity				
Man Who Has Sex with a Man/Gay	92	50	60	56
Heterosexual	58	31	26	24
Bisexual	20	11	11	10
Same Gender Loving	7	4	5	5
Other	7	4	4	4
Queer	3	2	3	3
Woman Who Has Sex with a Woman/Lesbian	1	1	0	0

**Numbers may not add to total n due to participant nonresponse for certain questions

^ Other race includes those as specified by participants outside of the above choices presented during survey administration

*Other ethnicity includes those as specified by participants outside of the above choices presented during survey administration

Table 105 presents participants' socio-demographics, including source of income/financial support, type of health insurance, and history of arrest. Salary/wages were the primary sources of income or financial support among those surveyed in the DMA (59%). 63% of participants reported having Medicaid/Healthy Michigan Plan/Medicare as their form of health insurance, followed by private insurance at 33%. 31% of participants reported having been arrested and put in a jail, detention center, or prison for longer than 24 hours.

Table 105: Socio-Demographics among persons living with HIV/AIDS, DMA, 2015

Characteristic	Michigan		DMA	
	n (n=191)**	%	n (n=107)**	%
Income/Financial Support				
Salary/Wages	75	41	63	59
SSI or SSDI	68	37	22	21
Family/Friends	13	7	7	7
Other Public Assistance	7	4	2	2
Pension/Retirement Fund	6	3	3	3
No Income/Financial Support	6	3	4	4
Unemployment Compensation	4	2	3	3
Other^	3	2	2	2
Savings/Investments	1	1	1	1
Type of Insurance*				
Medicaid/Healthy Michigan Plan/Medicare	162	89	66	63
Private	43	23	35	33
Ryan White	23	13	16	15
Other	10	5	8	8
No Health Insurance	4	2	4	4
Veterans Insurance	2	1	1	1
Ever Arrested±				
Yes	74	40		
No	110	60		
**Numbers may not add to total n due to participant nonresponse for certain questions				
^ Other income includes self-employed, sex worker, and student loans				
*Categories are not mutually exclusive				
±Question reads "Have you ever been arrested and put in a jail, detention center, or prison for longer than 24 hours?"				

Table 106 presents unstable housing situations as experienced by persons living with HIV/AIDS surveyed. Roughly a third of participants in the DMA reported having experienced an unstable housing situation in the past 12 months (33%). The most common unstable housing situations experienced were living with family/friends in a home the participant did not consider their home (83%), living on the street (23%), and living in a single room occupancy (SRO) hotel (17%).

Table 106: Unstable Housing among persons living with HIV/AIDS, DMA, 2015

Characteristic	Michigan		DMA	
	n (n=191)**	%	n (n=107)**	%
Unstable Housing^				
No	125	68	71	67
Yes	59	32	35	33
Housing Situations*±				
Lived with Family/Friends	45	76	29	83
Lived in Public/Private Shelter	14	24	5	14
Lived on the Street	12	20	8	23
Ever Lacked a Fixed/Regular/Adequate Place to Sleep	11	19	5	14
Lived in Any Other Unstable/Nonpermanent Situation	9	15	5	14
Lived in SRO Hotel	9	15	6	17
Lived in Transitional Housing	6	10	3	9
Lived in an Abandoned Building	6	10	5	14
Lived in a Public Place	4	7	3	9
Lived in a Car	4	7	4	11
Lived in a Jail/Prison/Correctional Facility	3	5	2	6

**Numbers may not add to total n due to participant nonresponse for certain questions

^ Question reads "During the past 12 months, have you experienced any of the following housing situations?"

Highlighted numbers signify top four responses in category

*Among those who answered "yes" to having experienced any of the listed housing situations

±Categories are not mutually exclusive

6.2.2 HIV TESTING, DIAGNOSIS AND PARTNER SERVICES

A. Testing and Diagnosis

Table 107 presents participants' history of HIV diagnosis, including age at diagnosis, time since diagnosis, setting of positive test and reason for getting tested at that time. A combined 72% of those surveyed in the DMA were between the ages of 18 and 35 when they were diagnosed, with an average age at diagnosis of 26. 46% were diagnosed with HIV more than 5 years ago, while 35% were diagnosed between 1 and 5 years ago and 20% were diagnosed within the past year. 30% of participants reported having tested positive for HIV in a health department, followed by a doctor's office and community HIV/STI testing site, each at 22%. Most PLWH surveyed reported being tested for HIV because they were concerned after having unprotected sexual contact (36%) or they felt sick or had an illness (26%).

Overall, those surveyed who were diagnosed with HIV within the past year in the DMA tended to be male (75%), were between the ages of 26 and 35 (40%), were black or African American (55%), and identified as MSM (45%). 40% of those newly diagnosed within the DMA reported experiencing an unstable housing situation within the past 12 months.

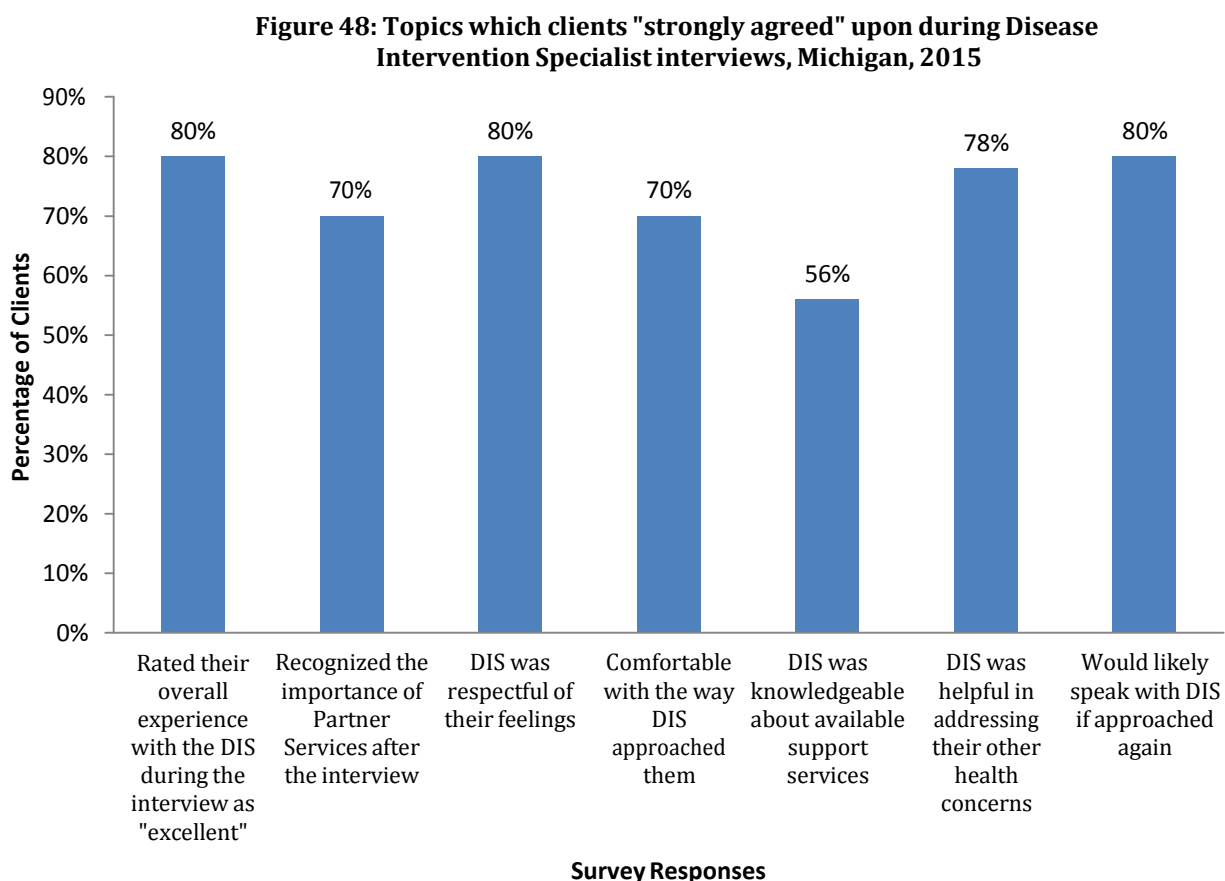
Table 107: History of diagnosis among persons living with HIV/AIDS, DMA, 2015

Characteristic	Michigan		DMA	
	n (n=191)**	%	n (n=107)**	%
Age at HIV Diagnosis (years)				
1-17	15	8	12	12
18-25	56	32	39	38
26-35	56	32	35	34
36-45	35	20	11	11
46-55	14	8	5	5
56+	1	1	0	0
Time Since Diagnosis				
Within the past 3 months	4	2	4	4
3 to 6 months ago	10	6	10	10
6 months to 1 year ago	11	6	6	6
1 to 5 years ago	55	30	37	35
More than 5 years ago	101	56	48	46
Setting of Positive Test				
Doctor's Office	50	27	23	22
Health Department	44	24	31	30
Community HIV/STI Testing Site	32	18	23	22
Emergency Room	25	14	16	15
Other^	14	8	6	6
Prison or Jail	10	5	3	3
Blood Bank/Plasma Center	4	2	2	2

Substance Abuse Treatment Center	2	1	0	0
Home Testing Kit	1	1	1	1
Reason for HIV Test				
Felt Sick or Had an Illness	56	31	27	26
Had Unprotected Sexual Contact	51	28	38	36
Routine HIV Test	31	17	18	17
Other*	25	14	14	13
Health Care Provider Recommended	24	13	12	11
Testing for Other STIs	22	12	17	16
Notified Partner was Positive	16	9	13	12
Donating Blood	7	4	4	4
Experienced Sexual Assault	6	3	4	4
Was Pregnant	5	3	3	3
Concerned Because Injecting Drugs	4	2	2	2
Required When Entering Prison	4	2	0	0
Required by Military, Court Order, Insurance	3	2	1	1
**Numbers may not add to total n due to participant nonresponse for certain questions				
^Other category includes: at college health clinic; Detroit military enlistment processing; free health center; HIV prevention truck; hospital and/or intensive care; in-home life insurance exam; mobile facility; tribal health clinic; and Veteran's hospital.				
*Other reasons include: beginning new relationship; fear; partner/former was sick; had other STI; received health coverage; had HIV symptoms; had risky lifestyle; partner asked or were tested together; was performing sex work; required by study; was applying for visa entry to US; and was refused health care unless tested.				

B. Partner Services

Just over half (55%) of PLWH surveyed in the DMA stated that they had participated in partner services for HIV or STIs. Among those who had participated in partner services, 22% reported that their overall experience was “excellent”, while 40% reported that it was “good”, 14% reported it as “neutral”, 12% reported it as “fair”, and 12% reported it as “poor”. Beyond this baseline data, further investigation into the experiences of PLWHA with Partner Services (PS) was not completed due to time constraints. However, to supplement these data are the results of an evaluation of the Disease Intervention Specialist (DIS) interviews for clients with Syphilis completed in May 2015 by MDHHS HIV Prevention staff. Part of this evaluation entailed the distribution of a 13-question client survey to assess the interaction between the client and the DIS as well as the client’s perspective of the original interview with the DIS worker. Although the generalizability of these survey results are limited due to a low client response rate, these results should be used as a basis for future needs assessment research into the perspectives of PLWHA regarding Partner Services. Relevant findings are shown below.



While there was little data on the client perspective, DIS were able to share their perspective and thoughts in focus groups and community providers were surveyed regarding their relationship with the DIS. The following reported findings were extracted from a larger evaluation project conducted for the STI Prevention Cooperative Agreement for their Targeted Evaluation Plan. These findings provide more insight into reasons a client may have a negative experience interviewing for Partner Services. These findings are not the direct quotes from the STI Targeted Evaluation Plan; rather, they are the summarized common themes expressed throughout that project. More in depth analysis can be found in the Evaluation report referenced below.

According to the DIS, a contributing factor to a client's poor experience with a PS interview is due to the lack of positive Partner Service messaging. Findings from DIS focus groups found that many DIS expressed that providers (doctors and staff at CBO's) do not explain PS to the client. Furthermore, in a partnership survey, community providers reported from client feedback, that the DIS judged them, they felt PS was a punishment, and felt that they were very much like a number, and not a person. Undoubtedly, further research needs to be conducted to better understand how the perception of clients towards PS can be improved.

Source: "An Evaluation of DIS Original Interviews for Primary and Secondary Syphilis Cases." Michigan Department of Health and Human Services, May 2015.

6.2.3 MEDICAL CARE

A. Initial Linkage to Medical Care

Table 108 presents the time from positive HIV diagnosis to linkage to medical care as well as ease of seeking medical care after diagnosis. The majority of DMA participants (69%) were linked to medical care within 3 months of their positive HIV diagnosis. When asked how easy or difficult it was to see a medical professional for HIV medical care after testing positive, only 39% described it as “very easy”. Among those participants who responded that seeking medical care after diagnosis was either “somewhat difficult” or “very difficult”, they were asked what made it so.

Table 108: Initial linkage to medical care among persons living with HIV/AIDS , DMA, 2015

Characteristic	Michigan		DMA	
	n (n=191)**	%	n (n=107)**	%
Time from Diagnosis to Linkage to Medical Care				
Less than 3 months after diagnosis	130	72	71	69
3 to 6 months after diagnosis	14	8	9	9
6 months to 1 year after diagnosis	11	6	7	7
More than 1 year after diagnosis	24	13	15	15
I never had HIV medical care	1	1	1	1
Ease of Seeking Medical Care for HIV After Diagnosis				
Very Easy	87	48	40	39
Somewhat Easy	34	19	26	25
Somewhat Difficult	28	16	17	17
Very Difficult	31	17	20	19

**Numbers may not add to total n due to participant nonresponse for certain questions

Table 109 presents, in rank order, the top 5 qualitative themes identified among participant responses regarding what made seeking medical care difficult after diagnosis. Table 110 presents, in rank order, the top 5 qualitative themes identified among participant responses regarding the most important things that should be done to make it as easy as possible for someone to get HIV medical care within 3 months of testing positive.

Those in the DMA who were not linked to care within 3 months were more likely to have been out of care either 6 months or more or 12 months or more during the past 2 years (43%) compared to those in the general DMA survey population (30%). A combined 52% of those not linked to care within 3 months were between the ages of 26 and 45, while 29% were age 56 or older.

Table 109: Things that made it difficult to seek medical care after diagnosis among persons living with HIV/AIDS, DMA, 2015

Michigan

1. Had a hard time accepting that diagnosis was real
 2. I was scared about being diagnosed with HIV
 3. I didn't know where to go for medical care
 4. I was embarrassed
-

DMA

1. Did not know where to go
 2. Had a hard time accepting the diagnosis
 3. I was embarrassed
 4. I was scared
-

Table 110: Things that ease the immediate receipt of medical care after diagnosis among persons living with HIV/AIDS, DMA, 2015

Michigan

1. At time of diagnosis, provide immediate assistance with scheduling of appointment(s), referral to a local doctor or specialist and access to medication(s)
 2. Provide information to increase knowledge of HIV, along with why it is important to see a doctor immediately, and the available options for medical care and resources
 3. Provide social and emotional support at time of diagnosis, including mental health counseling
 4. Immediate access to case management and community organizations who provide resources for PLWHA
 5. Easy access to insurance and help with medical costs
-

DMA

1. At time of diagnosis, provide immediate assistance with scheduling of appointment(s), referral to a local doctor or specialist and access to medication(s)
 2. Provide information to increase knowledge of HIV, along with why it is important to see a doctor immediately, and the available options for medical care and resources
 3. Immediate access to case management and community organizations who provide resources for PLWHA
 4. Transportation assistance to medical services
 5. Easy access to insurance and help with medical costs
-

B. Current Receipt of Medical Care

The majority (67%) of PLWH surveyed in the DMA stated that it is “very easy” to access medical care now, while 34% contend that it either remains only “somewhat easy” (25%), that it is “somewhat difficult” (8%), or that it is “very difficult” (1%). Table 1112 presents the top qualitative themes regarding what helps participants get medical care now among those who said that current access to medical care for them is “very easy” or “somewhat easy”. Table 112 presents the top qualitative themes regarding what makes it difficult to get medical care now among those who said that current access to medical care for them is “somewhat difficult” or “very difficult”.

Table 111: Things that help you get medical care among persons living with HIV/AIDS, DMA, 2015

Michigan
1. Access to medical insurance and having the ability to pay for care
2. Support and resources from medical care providers and staff
3. Personal responsibility to seek and obtain care
4. Assistance from case manager, counselor, or community organization
DMA
1. Access to medical insurance and having the ability to pay for care
2. Social support from peers, family and friends
3. Support and resources from medical care providers and staff
4. Personal responsibility to seek and obtain care

Table 112: Things that make it difficult to get medical care now among persons living with HIV/AIDS, DMA, 2015

Michigan
1. Lack of transportation to medical care
2. Lack of insurance and financial assistance to cover medical care and medication costs
DMA
1. Lack of insurance and financial assistance to cover medical care and medication costs
2. Lack of transportation to medical care

C. Retention in Care

Table 113 presents care retention data among persons living with HIV/AIDS surveyed. Retention here was defined as seeing a doctor, nurse or other medical case worker for HIV medical care every 6 or 12 months during the past 2 years. Just over two-thirds of PLWH surveyed in the DMA were retained in care during the past 2 years (68%), while 30% were either out of continuous care (no contact with a doctor, nurse or other medical case worker for 6 months or longer), or completely out of care (no contact with a doctor, nurse or other medical case worker for 12 months or longer [24%]). Among those who were out of care for either of these periods, the primary reasons given for being out of care were:

- not wanting to think about being HIV positive (57%)
- forgetting or missing an appointment (40%)

Among those who reported having been out of care for 6 months or more or 12 months or more in the DMA, 87% reported returning to care. This data does come with a caveat, as survey participants could have reported not having seen a doctor, nurse, or other health care worker for HIV medical care for either 6 months or more or 12 months or more, and still could have been prescribed and taking HIV medications.

A higher proportion of those who were out of care for either 6 months or more in the DMA were linked to medical care more than 3 months after diagnosis (43% compared with 30% in the general DMA survey population) and experienced an unstable housing situation within the past 12 months (55% compared with 33% in the general survey population). Nearly all (94%) of those out of care in the DMA had been diagnosed with HIV more than 5 years ago, though only 68% reported being virally suppressed, compared with 73% in the general DMA survey population.

Table 113: Retention in care among persons living with HIV/AIDS, DMA, 2015

Characteristic	Michigan		DMA	
	n (n=191)**	%	n (n=107)**	%
Out of Care 6 Months or Longer in Past 2 Years				
Yes	14	8	6	6
No	134	74	71	69
Out of Care 12 Months or Longer in Past 2 Years				
Yes	31	17	25	24
No	149	83	78	76
Combined 6 Months & 12 Months Out of Care				
Yes	45	25	31	30
No	133	74	70	68
Reasons for Not Being In Care^				
Didn't want to think about being HIV positive	22	50	17	57
I felt fine and didn't think I needed to go	17	39	11	37
I forgot or missed my appointment	15	34	12	40
I was unable to get transportation	14	32	11	37
I was homeless or did not have a steady place to live	14	32	9	30
Other*	11	25	5	17
I didn't have enough money or health insurance	11	25	8	27
My CD4 count and viral load are good	11	25	9	30
I had other responsibilities (work, child care)	9	20	7	23
I didn't feel comfortable going there	9	20	6	20
I was drinking or using drugs	8	18	5	17
I was unable to get an appointment	6	14	3	10
I felt too sick to go	6	14	4	13
Stigma related to HIV	5	11	5	17
I didn't like the way I was treated	3	7	2	7
I was incarcerated	3	7	3	10
Clinics/Offices are not private	3	7	0	0
I didn't know where to go	3	7	3	10
My doctor told me I only need to go once a year	2	5	2	7

**Numbers may not add to total n due to participant nonresponse for certain questions

^ Categories are not mutually exclusive

*Other reasons include: depression; wasn't contacted about my appointment; didn't feel it was necessary; family issues; forgot to take medication; didn't know I was positive; too long of a drive; have children with health issues and am overwhelmed with appointments; medications were stopped; and was taking care of family member out of state.

Those who reported remaining in care for the past 2 years were asked what has helped them stay in care, with table 114 presenting the top qualitative themes elicited from their responses. Those who reported having been out of care but returned to care were asked what most helped them get reconnected with HIV medical care, with table 115 presenting the top qualitative themes elicited from their responses. All participants were asked what they believe to be the most important things that should be done to help someone stay in care without dropping out or taking a break, and the top qualitative themes elicited from their responses are presented in table 116.

Table 114: What has helped you stay in care without stopping or taking a break during the past 2 years among persons living with HIV/AIDS, DMA, 2015

Michigan
1. Personal responsibility to seek care and maintain good health
2. Support from family and friends
3. Fear of becoming ill or health deteriorating
4. Easy access to medical care and medication(s)
DMA
1. Personal responsibility to seek care and maintain good health
2. Support from family and friends
3. Receiving quality medical care
4. Being recently diagnosed and haven't dropped out of care

Table 115: What helped you get reconnected with care among persons living with HIV/AIDS, DMA, 2015

Michigan
1. Sought care through self-initiative
2. Help and motivation from friends and family
3. Received help from case manager, counselor, or community organization
4. Returned to care after becoming ill or fear of becoming ill
5. Received support and encouragement from medical care staff
DMA
1. Sought care through self-initiative
2. Help and motivation from friends and family
3. Returned to care after becoming ill or fear of becoming ill
4. Received support and encouragement from medical care staff

**Table 116: What can be done to help persons living with HIV stay in care without stopping or taking a break,
DMA, 2015**

Michigan

1. Having an active support system
 2. Provide education on the importance of staying in care
 3. Having a case manager who maintains contact with PLWH
 4. Having culturally competent doctors, and doctors with good bedside manners
 5. Having insurance and coverage for medical services
-

DMA

1. Having an active support system
 2. Provide education on the importance of staying in care
 3. Having culturally competent doctors, and doctors with good bedside manners
 4. Having a case manager who maintains contact with PLWH
 5. Having insurance and coverage for medical services
-

D. Viral Suppression

Eighty nine percent of persons living with HIV/AIDS surveyed in the DMA reported having a viral load test within the past year, while 8% reported having a test 1 to 2 years ago, 2% reported having a test 3 to 4 years ago, and 1% reported never having a viral load test. Among those who had a viral load test, 73% had been told they were virally suppressed or had an undetectable viral load; the remaining either had not been told they were virally suppressed/undetectable (17%) or were unsure (10%).

6.2.4 INITIAL LINKAGE TO CASE MANAGER

Sixty eight percent of persons living with HIV/AIDS surveyed in the DMA reported ever having used a case manager since their HIV diagnosis. 58% of participants who had used a case manager stated that they were initially linked to one within 3 months of their diagnosis, compared to 17% who were linked 3 to 6 months after diagnosis, 3% between 6 months to 1 year, and 23% more than 1 year after being diagnosed with HIV. Table 117 presents the top qualitative themes elicited among participant responses regarding the most important things that should be done to make it as easy possible for someone to get connected to a case manager within 3 months of testing positive.

Table 117: Things the ease initial linkage to a case manager within 3 months of diagnosis among persons living with HIV/AIDS, DMA, 2015

Michigan
1. Have medical care options explained at the time of testing and a list of local organizations that can provide case management services
2. Have open and honest communication at time of diagnosis, specifically to address any mental health concerns and provide social support
3. Immediately link or refer at time of diagnosis to a case manager or organization that provides these services
DMA
1. Have open and honest communication at time of diagnosis, specifically to address any mental health concerns and provide social support
2. Have medical care options explained at the time of testing and a list of local organizations that can provide case management services
3. Immediately link or refer at time of diagnosis to a case manager or organization that provides these services

6.2.5 HIV MEDICATIONS

Ninety percent of persons living with HIV/AIDS surveyed in the DMA reported currently taking HIV medications, although 51% reported having skipped or missed a dose of their medication during the past 30 days. When asked how easy or difficult it was to take their HIV medications without skipping or missing any doses, 49% stated it was “very easy”, 30% stated it was “somewhat easy”, 14% stated it was “somewhat difficult”, and 6% stated it was “very difficult”. Table 118 presents the top qualitative themes elicited among participant responses regarding those things identified as helping participants take their HIV medications without skipping or missing a dose.

Table 118: What helps persons living with HIV/AIDS take HIV medications without skipping or missing a dose, DMA, 2015

Michigan

1. Making taking the medications a part of my routine or habit
2. Desire to maintain good health
3. Setting alarms and daily reminders
4. Medication is sorted into daily pill boxes/sorters

DMA

1. Setting alarms and daily reminders
 2. Making taking the medications a part of my routine or habit
 3. Desire to maintain good health
 4. Medication is sorted into daily pill boxes/sorters
-

6.2.6 MANAGING INFECTION & CHALLENGES EXPERIENCED

When asked to rate themselves on the management of their HIV infection, the majority respondents in the DMA reported managing their infection well (77%), followed by those who manage it okay (16%), those who manage it poorly (3%), those who do not manage it at all (2%), and those who were unsure (2%). Participants also reported the challenges they had experienced since becoming diagnosed with HIV, with the most common challenge being “telling friends/family about my HIV status” (42%) followed by “telling my sex partners about my HIV status” (40%). Table 119 presents the challenges experienced among PLWH surveyed.

Table 119: Challenges experienced since testing positive among persons living with HIV/AIDS, DMA, 2015

Characteristic	Michigan		DMA	
	n (n=191)**	%	n (n=107)**	%
Challenges^				
Telling friends/family about HIV status	67	37	39	42
Meeting people I can relate to	65	36	34	37
Paying copays for prescription drugs	60	33	27	29
Telling sex partners about HIV status	59	33	37	40
Maintaining stable housing (rent, mortgage, etc.)	58	32	25	27
Feeling trapped, damned, or doomed	57	31	28	30
Paying medical bills	56	31	26	28
Meeting other HIV positive people	55	30	30	32
Feeling confident I won't infect others	50	28	27	29
Finding employment or staying employed	49	27	21	23
Maintaining insurance coverage	50	28	34	37
Getting to doctor's appointments or other services	45	25	26	28
Practicing safer sex	38	21	24	26
Talking about healthy relationships	32	18	17	18
Abusing alcohol/drugs	30	17	17	18
Having access to food or feeding my family	30	17	13	14
Finding an HIV doctor near me	22	12	12	13
Other*	19	10	4	4
Having access to condoms	18	10	7	8
Finding support for my children	4	2	4	4
Accessing clean/sterile needles/works	1	1	0	0

**Numbers may not add to total n due to participant nonresponse for certain questions

^ Categories are not mutually exclusive

*Other challenges include: anxiety, stress, depression and mental health; finding accepting partner; feeling dirty; getting SSI/SSDI; health problems; difficulty finding love; domestic violence; pain and pain management; stigma; and wanting to have children.

6.2.7 SUPPORT SERVICES AND PROGRAMS

Table 120 presents the support services that persons living with HIV/AIDS surveyed reported needing in the past 12 months. The majority of respondents in the DMA reported needing dental care (50%) followed by mental health care (45%). It should be noted that these responses may include services participants have needed and have not received, as well as have needed and have received.

Table 120: Support services needed during the past 12 months among persons living with HIV/AIDS, DMA, 2015

Characteristic	Michigan		DMA	
	n (n=191)**	%	n (n=107)**	%
Services Needed^				
Dental care	99	55	52	50
HIV case management services	87	48	40	38
Mental health services	78	43	47	45
Transportation assistance	73	41	31	30
Medicine through ADAP	67	37	35	34
Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI)	66	37	25	24
Meal or food services	65	36	28	27
HIV peer group support	64	36	39	38
HIV prevention counseling	44	24	26	25
Shelter or housing services	44	24	20	19
Insurance enrollment assistance	34	19	17	16
Nutritional services	30	17	21	20
Professional help remembering to take HIV medicines	22	12	12	12
Drug or alcohol counseling/treatment	22	12	13	13
Home health services	16	9	5	5
Other*	12	7	3	3
Childcare services	5	3	4	4
Domestic violence services	1	1	0	0
Interpreter services	1	1	1	1

**Numbers may not add to total n due to participant nonresponse for certain questions

^ Categories are not mutually exclusive

*Other services include: care for hepatitis C; chiropractic services; assistance paying bills and other housing assistance; hormones; legal services; spiritual support; and other insurance assistance.

A. HIV Programs & Information

Respondents were asked about previous participation and interest in individual, group, or linkage prevention programs (Table 121). Twenty two percent of respondents in the DMA had not participated in any programs. The most popular program in the DMA was Healthy Relationships.

Table 121: Program use and interest among persons living with HIV/AIDS, DMA, 2015

Characteristic	Michigan		DMA	
	n (n=191)**	%	n (n=107)**	%
Programs Utilized by Participants^				
Group program: "Healthy Relationships"	42	24	24	23
Linkage program: "Antiretroviral Treatment and Access to Services" (ARTAS)	13	8	7	7
Group program: "Mpowerment"	19	11	12	12
Individual program: "Individual Level HIV Risk Reduction Counseling" (ILRRC)	17	10	7	7
The group program "Prevention Options for Positives" (POP)	24	14	13	13
I don't know	36	21	30	29
None	51	29	23	22
Other similar programs*	38	22	23	22
Interest in Group/Individual Interventions				
Am interested	134	75	80	77
Am not interested	45	25	24	23
Populations to Participate With^				
Persons living with HIV (PLWH)	117	87	68	85
Men who have sex with men (MSM)	88	66	55	69
Youth	63	47	35	44
Transgender persons	45	34	21	26
Other±	14	10	3	4

**Numbers may not add to total n due to participant nonresponse for certain questions

^Categories are not mutually exclusive

*Other programs include: Brothers Saving Brothers (BSB); Camps for HIV positive persons; EIS; general support groups at community based organizations; HELP; Lighthouse; Life Skills; Moms in Motion; Sista; smoking cessation groups; TEAMS; and unspecified women's support groups.

±Other populations include: anyone; at risk youth contemplating suicide; homeless; heterosexuals; spiritual groups; youth or high school students; women; and women who have sex with women/lesbians.

Participants were also asked which topics, if any, they would be most interested in learning about. Eighty percent of persons living with HIV/AIDS surveyed in the DMA stated that they would like to learn more about one or more topics. Of those who stated that they wanted to learn more about a topic, the majority wanted to learn more about stress reduction (73%). Table 122 presents participants' interest in learning more about various topics.

Table 122: Topics of interest among persons living with HIV/AIDS, DMA, 2015

Characteristic	Michigan		DMA	
	n (n=191)**	%	n (n=107)**	%
Topics^				
Stress Reduction	105	73	62	73
Feeling better about myself and my HIV status	85	59	50	59
Disclosing my HIV status to a sexual partner	53	37	37	44
Disclosing my HIV status to family/friends	51	35	31	36
Talking to my partner about healthy relationships	51	35	30	35
How to reduce the spread of HIV and STIs	51	35	32	38
Skill building on medication adherence	43	30	23	27
How to access medical care and support services	42	29	20	24
How to practice safer sex	37	26	20	24
Maintaining a monogamous relationship	37	26	22	26
How to avoid alcohol use	29	20	15	18
How to avoid drug use	28	19	15	18
How to use condoms or dental dams	17	12	9	11
Other*	16	11	4	5
Reducing my number of sexual partners	15	10	10	12

**Numbers may not add to total n due to participant nonresponse for certain questions

^Categories are not mutually exclusive

*Other topics include: accessing DHS network for health insurance and food stamps; anger management; becoming a peer supporter; greater involvement in churches; having children while HIV positive; pursuing legal repercussions for status disclosure without permission; how to deal with HIV while dealing with other medical issues; information on PrEP; smoking cessation; and weight management.

6.2.8 PREP KNOWLEDGE AND ATTITUDES

Table 123 presents participants' knowledge and attitudes regarding pre-exposure prophylaxis, or PrEP. The majority of PLWH surveyed in the DMA had either heard of an HIV prevention pill or had heard specifically about PrEP (78%), and 48% knew anyone who was currently using PrEP. Most participants would encourage an at-risk friend to take PrEP (96%).

Table 123: PrEP knowledge & attitudes among persons living with HIV/AIDS , DMA, 2015

Characteristic	Michigan		DMA	
	n (n=191)**	%	n (n=107)**	%
Heard of Prevention Pill or PrEP				
Yes	122	68	80	78
No	57	32	23	22
Know Anyone on PrEP				
Yes	46	38	38	48
No	76	62	42	53
Encourage At-Risk Friend to Take PrEP				
I would	113	93	77	96
I would not	9	7	3	4
Know Where to Get PrEP				
Yes	92	75	56	70
No	30	25	24	30
**Numbers may not add to total n due to participant nonresponse for certain questions				

6.2.9 IMPROVING HIV SERVICES

Table 124 presents the responses among PLWH surveyed regarding the ways HIV care providers could better serve their clients; over half in the DMA stated “know what HIV related services are available in my area and provide referrals” (62%) and “be more experienced/knowledgeable about providing HIV care” (55%).

Table 124: Ways that providers can better serve persons living with HIV/AIDS, DMA, 2015

Characteristic	Michigan		DMA	
	n (n=191)**	%	n (n=107)**	%
Ways to Better Serve PLWH				
Know HIV services in area/provide referrals	104	65	60	62
More experience/knowledge regarding HIV care	87	54	53	55
Advocate for client needs within service system	78	48	43	44
Greater LGBTQ sensitivity and experience	64	40	41	42
More convenient office hours	59	37	43	44
Provide services in more convenient location	59	37	37	38
Reduce appointment wait times	56	35	38	39
Make appointments quicker	55	34	35	36
Greater cultural sensitivity and experience	53	33	31	32
Know a language other than English	39	24	22	23
Other*	20	12	13	13

**Numbers may not add to total n due to participant nonresponse for certain questions

^Categories are not mutually exclusive

*Other category includes: after hours phone service with providers; ability to see only one doctor or keep one infectious doctor; promptly respond to phone calls or messages; be better informed; be more client oriented and spend more time with clients; be more confidential; improved bedside manner; streamline services; and nothing could be done to improve services.

Participants were also asked what most important change they would suggest to improve services for individuals or families living with HIV, and the top qualitative themes elicited from their responses are provided in table 125.

Table 125: Most important change to improve services, DMA, 2015

Michigan

1. No suggestions for improvement – the current system works
2. Increase support groups and mental health support
3. Increase access to medical care and community resources
4. Expand HIV care education

DMA

1. Increase access to medical care and community resources
 2. Increase support groups and mental health support
 3. No suggestions for improvement – the current system works well
 4. Expand HIV care education
-

SECTION 6.2 SUMMARY: SURVEY OF PERSONS LIVING WITH HIV/AIDS IN THE DMA

- A total of 107 surveys were administered in the DMA with participants from Wayne, Oakland and Macomb counties. This survey is not representative of the entire DMA and does not include information on clients from St. Clair or Lapeer. Data from this survey should be used in addition to other secondary data sources.
- More than half of participants were between the ages of 18-35, the majority were male and over half were black/African American.
- Over half identified as MSM, while 24% were heterosexual and 10% were bisexual.
- Salary/wages were the primary forms of financial support for participants.
- 63% of participants were on Medicaid, Medicare, or the Healthy Michigan Plan, followed by 33% on private insurance
- A third of participants had experienced an unstable housing situation in the past 12 months.
- 31% had been arrested and put in a jail, detention center, or prison for longer than 24 hours.
- 72% of participants were between the ages of 18 and 35 when they were diagnosed with HIV; most tested positive at a health department, a doctor's office or a community HIV/STI testing site. Most were tested because they were concerned after having unprotected sexual contact.
- Those diagnosed in the past year tended to be male, were between the ages of 26 and 35, were black/African American, and identified as MSM; 40% of those newly diagnosed experienced an unstable housing situation in the past 12 months.
- 69% were linked to HIV medical care within 3 months of diagnosis; those not linked to medical care within 3 months tended to be between the ages of 26 and 45.
- 68% of participants had used a case manager since being diagnosed with HIV, though just over half were linked to a case manager within 3 months of their diagnosis.
- 30% of participants were out of care for either 6 months or longer or 12 months or longer in the past 2 years; most were out of care because they didn't want to think about being HIV positive or they forgot or missed their appointment.
- Those who were out of care were more likely to have linked to medical care more than 3 months after their diagnosis and were more likely to have experienced an unstable housing situation in the past 12 months.
- The top challenges experienced by participants included telling friends/family about their HIV status, telling sex partners about their HIV status, meeting people they can relate to, and maintaining insurance coverage.
- The top support services needed by participants were dental care, mental health services, HIV peer group support, and HIV case management services.
- Most participants were interested in learning more about stress reduction, how to feel better about themselves and their HIV status, and how to disclose their status to sex partners.
- Most participants stated that HIV care providers could better serve them by knowing what HIV services are in their area and providing referrals, being more knowledgeable about providing HIV care, and having more convenient office hours.

- Participants felt that increased social support and mental support, expanded HIV education and increased access to community resources were the most important changes that could help improve services.

6.3. SURVEY OF PERSONS AT-RISK FOR HIV/AIDS

As part of the Themes and Strengths portion of the MAPP assessment (see Section 1.1 Needs Assessment Process), a statewide, in-person survey was conducted among persons at risk for HIV/AIDS. The purpose of this primary data collection was to supplement and address gaps in existing secondary data within the state. An original survey, consisting primarily of multiple choice questions, was developed by MPHI with feedback and input from the Themes and Strengths and Steering Committees. Survey topics included history of HIV testing, participation in risky behaviors, HIV/STI prevention education, partner services, prevention of HIV, and knowledge and attitudes regarding pre-exposure prophylaxis (PrEP). This survey is not representative of the DMA and does not include information on clients from St. Clair or Lapeer. Data from this survey should be used in addition to other secondary data sources. A copy of the survey tool can be found in the Appendix.

Participants were recruited with the assistance of local health departments, HIV/AIDS service organizations (ASOs), community based organizations (CBOs), HIV/AIDS prevention support groups, testing facilities, and social settings as referred by members of the Steering Committee and Subcommittees. Organizations were asked to target recruitment efforts to persons at risk for HIV from specific groups (e.g., young black men who have sex with men, transgender individuals, injecting drug users, high risk heterosexuals, etc.). Several organizations and support groups were chosen as recruitment locations because their primary client population represented one of our target groups.

Surveys were administered in a private location by trained interviewers or self-administered if a participant preferred to do so. The consent process and administration of the survey took anywhere from 30 to 40 minutes to complete and respondents were provided a \$20 Visa gift card for their time. Data from multiple choice questions were analyzed using the Statistical Package for the Social Sciences (SPSS) and are presented using descriptive statistics. Surveys were not audio-recorded, thus all answers to open-ended questions consisted of notes written by interviewers or participants, with few verbatim, direct quotes. Data from open ended questions were coded and organized into themes. Responses under each theme were enumerated and themes were presented in rank order.

The research protocol, survey, informed consent sheet, and all recruitment materials were approved by the Institutional Review Board (IRB) at the Michigan Public Health Institute in Okemos, Michigan and the Michigan Department of Health and Human Services IRB in Lansing, Michigan.

6.3.1 DEMOGRAPHICS AMONG PERSONS AT RISK FOR HIV SURVEYED, DMA

Trained survey administrators traveled to recruitment sites throughout the state, administering a total of 51 surveys to individuals at-risk for HIV. The majority of these surveys, or 80%, were administered in Wayne, Oakland and Macomb counties within the Detroit Metropolitan Statistical Area (DMA, comprised of Wayne, Oakland, Lapeer, Macomb, Monroe and St. Clair counties). Figure 49 presents the counties in which primary data were collected. Data in this section will be presented only for those participants surveyed in the DMA.

Table 126 presents demographics among the persons at-risk surveyed in the DMA, including age, gender, race, ethnicity, and sexual identity. Just over half of those surveyed were between the ages of 18 and 25 years (51%), most were male (78%), and just over half were black/African American (51%). 49% of participants identified as men who have sex with men, followed by 21% who identified as bisexual.

Figure 49: County of residence among persons at-risk for HIV infection surveyed, DMA, 2015

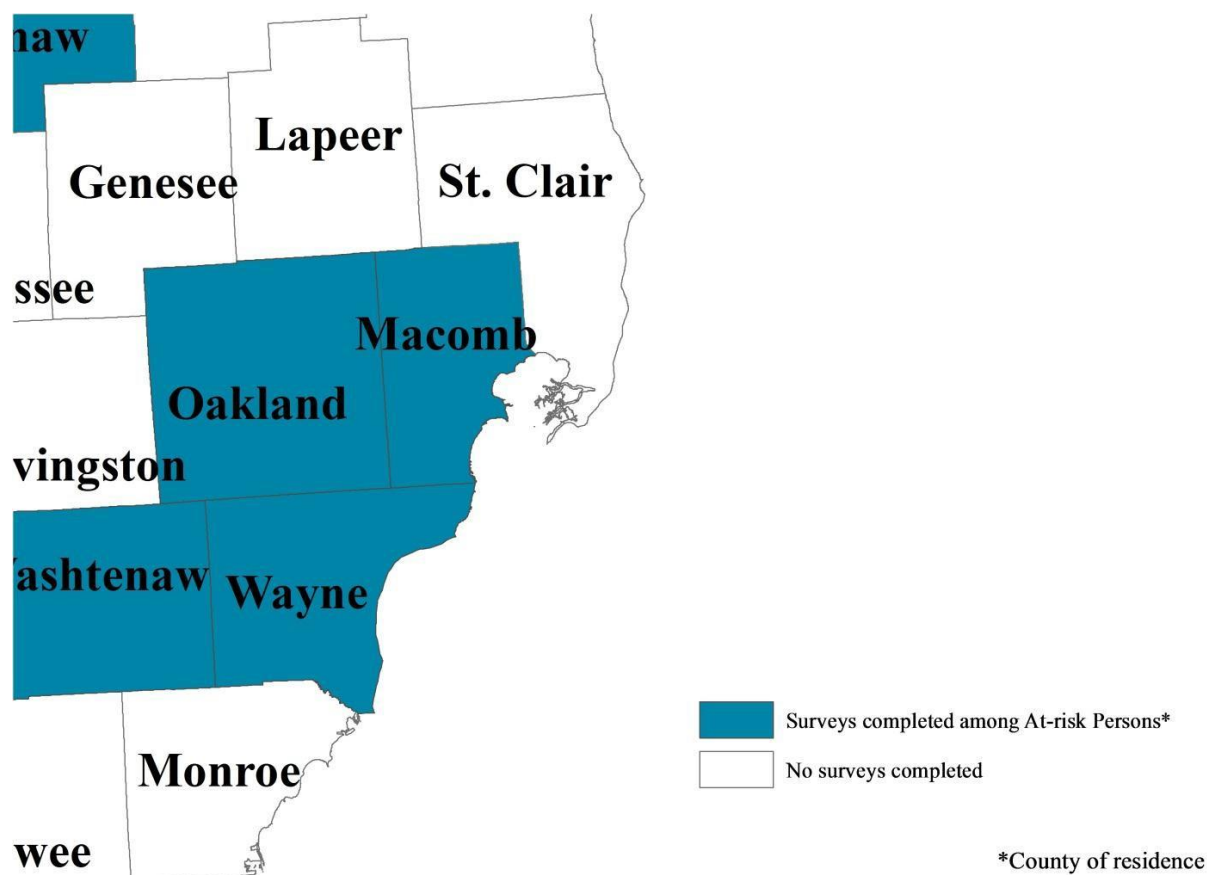


Table 126: Demographics among persons at-risk for HIV/AIDS, DMA, 2015

Characteristic	DMA	
	n (n=41)**	%
Age (years)		
18-25	21	51
26-35	14	34
36+	6	15
Gender		
Male	32	78
Female	4	10
Transgender	4	10
Genderqueer	1	2
Race		
Black/African American	21	51
White	11	27
Multiracial	7	17
Asian	1	2
Other^	1	2
Ethnicity		
Not Applicable	27	68
Unknown	5	13
Other*	4	10
Hispanic/Latino	1	3
Arab/Chaldean	3	8
Sexual Identity		
Man Who Has Sex with a Man/Gay	19	49
Bisexual	8	21
Heterosexual	7	18
Same Gender Loving	4	10
Queer	3	8

**Numbers may not add to total n due to participant nonresponse for certain questions

^Other race includes American Indian/Alaska Native

*Other ethnicity includes Black Puerto Rican (n=1), Indian and Black (n=1), Serbian (n=1), and did not specify (n=1).

Table 127 presents the socio-demographics of participants in the DMA, including source of income/financial support, type of health insurance, and history of arrest. Salary/wages were the primary sources of income or financial support among persons at-risk surveyed (71%). Just over half of participants reported having private insurance (55%), followed by Medicaid/Healthy Michigan Plan/Medicare (40%). 27% of participants reported having been arrested and put in a jail, detention center, or prison for longer than 24 hours.

Table 127: Socio-demographics among persons at-risk for HIV/AIDS, DMA, 2015

Characteristic	DMA	
	n (n=41)**	%
Income/Financial Support^		
Salary/Wages	29	71
Family/Friends	6	15
SSI/SSDI	4	10
Other*	3	7
Unemployment Compensation	2	5
Savings/Investments	2	5
No Income/Financial Support	1	2
Other Public Assistance	0	0
Pension/Retirement Fund	0	0
Type of Insurance		
Private	22	55
Medicaid/Healthy Michigan Plan/Medicare	16	40
No Health Insurance	2	5
Veterans Insurance	1	3
Ever Arrested±		
Yes	11	27
No	30	73
**Numbers may not add to total n due to participant nonresponse for certain questions		
^ Categories are not mutually exclusive		
*Other income includes settlement (n=1), small business owner (n=1) and student loans (n=1)		
±Question reads "Have you ever been arrested and put in a jail, detention center, or prison for longer than 24 hours?"		

Table 128 presents unstable housing situations as experienced by persons at-risk surveyed in the DMA. Over a third of participants reported having experienced an unstable housing situation in the past 12 months (37%). The most common unstable housing situation experienced was living with family/friends in a home the participant did not consider their home (80%).

Table 128: Unstable housing among persons at-risk for HIV/AIDS, DMA, 2015

Characteristic	DMA	
	n (n=41)**	%
Unstable Housing[^]		
No	26	63
Yes	15	37
Housing Situations*[±]		
Lived with Family/Friends	12	80
Lived in Any Other Unstable/Nonpermanent Situation	6	40
Lived on the Street	3	20
Lived in a Car	3	20
Lived in Transitional Housing	2	13
Lived in SRO Hotel	2	13
Lived in an Abandoned Building	2	13
Ever Lacked a Fixed/Regular/Adequate Place to Sleep	2	13
Lived in Public/Private Shelter	1	7
Lived in a Jail/Prison/Correctional Facility	1	7
Lived in a Public Place	1	7
**Numbers may not add to total n due to participant nonresponse for certain questions		
[^] Question reads “During the past 12 months, have you experienced any of the following housing situations?”		
*Among those who answered “yes” to having experienced any of the listed housing situations		
[±] Categories are not mutually exclusive		

6.3.2 HIV TESTING

Table 129 presents DMA participants' history of HIV testing, including ever been tested for HIV, time since most recent HIV test, setting of most recent HIV test, and reason for getting most recent HIV test. Nearly all persons at-risk surveyed reported having had an HIV test (97%), though it should be noted that participants were primarily recruited from community organizations and health departments in which HIV testing occurs. 80% of participants had an HIV test within the past year, and over half had been tested most recently at community HIV/STI testing site (60%). The majority of participants were tested because they were concerned after having unprotected sexual contact (63%) or they were receiving a routine HIV test (46%).

Table 129: History of testing among persons at-risk for HIV/AIDS, DMA, 2015

Characteristic	DMA	
	n (n=41)**	%
Ever Tested for HIV		
Yes	35	97
No	1	3
Time Since Most Recent HIV Test		
Within the past year	28	80
1 to 2 years ago	2	6
3 to 4 years ago	3	9
More than 5 years ago	2	6
Setting of Most Recent HIV Test		
Community HIV/STI Testing Site	21	60
Doctor's Office	8	23
Other^	3	9
Health Department	2	6
Emergency Room	1	3
Prison or Jail	0	0
Reason for HIV Test		
Concerned about unprotected sexual contact	22	63
Getting routine HIV test	16	46
Tested for other STIs	11	31
Other*	5	14
Health care provider recommended I get tested	3	9
Notified partner was HIV positive	2	6
Needle stick follow up or occupational exposure	2	6
Experienced sexual assault	2	6
I was pregnant	0	0
Injected drugs with a needle	0	0
Felt sick or had an illness	0	0
Donated blood	0	0
Required by military, court order, insurance	0	0
**Numbers may not add to total n due to participant nonresponse for certain questions		

^Other setting of HIV test includes club (n=1), Detroit Job Corps (n=1) and Menjo's Night Club (n=1).

*Other reasons for HIV test include asking for PrEP prescription (n=1), getting a check-up/routine physical (n=2), was concerned after risky behaviors (n=1), and was getting married (n=1).

6.3.3 MEDICAL CARE

Participants were asked if they had gone to the doctor in the past year for a non-emergency visit and if so, whether their health care provider had offered them an HIV test. 62% of those surveyed in the DMA reported having seen a doctor, though only 35% of those were offered an HIV test.

6.3.4 HEALTH BEHAVIORS

Most (84%) of persons at-risk surveyed reported having had unprotected sex with a non-monogamous partner. Table 130 presents risky behaviors engaged in by participants; the most common risky behavior was oral sex (mouth-penis) (90%), followed by insertive anal sex without a condom (79%).

Table 130: Health behaviors among persons at-risk for HIV/AIDS, DMA, 2015

Characteristic	DMA	
	n (n=41)**	%
Risky Behavior		
Oral sex (mouth-penis)	35	90
Insertive anal sex without a condom	31	79
Insertive anal sex with a condom	26	67
Oral sex (mouth-anus/rimming)	24	62
Receptive anal sex without a condom	21	54
Receptive anal sex with a condom	20	51
Vaginal sex without a condom	14	36
Vaginal sex with a condom	11	28
Oral sex (mouth-vagina)	10	26
Injecting drugs that were not prescribed to be by physician	1	3
Sharing needles for drug use	0	0
Sharing other works for injecting drug use	0	0
Blood transfusion/receipt of blood products	0	0
I don't know	0	0
Other	0	0

**Numbers may not add to total n due to participant nonresponse for certain questions

Categories are not mutually exclusive

6.3.5 HIV/STI PREVENTION EDUCATION

The majority of persons at-risk who were surveyed reported having received HIV/STI prevention education (90%), and over half had received this education from a community based organization (61%). Table 131 presents HIV/STI prevention education data from persons at-risk who participated in the survey.

Table 131: HIV/STI Prevention education among persons at-risk for HIV/AIDS, DMA, 2015

Characteristic	DMA	
	n (n=41)**	%
Received HIV/STI Prevention Education		
Yes	36	90
No	4	10
Setting of HIV/STI Prevention Education^		
Community based organization	22	61
School	12	33
Medical setting	10	28
Other*	4	11
**Numbers may not add to total n due to participant nonresponse for certain questions		
^Categories were not mutually exclusive		
*Other setting includes gay club/bar (n=1), HIV positive friends (n=1), Horizons (n=1), Michigan Dept. of Corrections (n=1), with a performance group (n=1) and did not specify (n=1).		

Participants were also asked which topics, if any, they would be most interested in learning more about; topics included stress reduction, avoiding drug and alcohol use, and practicing safe sex, among others. Table 132 presents participants responses regarding learning further about these topics. Among the 90% interested in learning more, most were interested in learning more about stress reduction (54%), followed by maintaining a monogamous relationship (41%) and skill building on how to reduce the risk of HIV/STIs (38%).

Table 132: Topics of interest among persons at risk for HIV/AIDS, DMA, 2015

Characteristic	DMA	
	n (n=41)**	%
Topics^		
Stress reduction	21	54
Maintaining a monogamous relationship	16	41
Skill building to reduce spread of HIV/STIs	15	38
Accessing medical care and support services	12	31
How to talk to partner(s) about HIV/STIs	11	28
Reducing number of sexual partners	11	28
How to avoid drug use	7	18
How to use condoms or dental dams	6	15
How to avoid alcohol use	3	8
Other*	2	5
**Numbers may not add to total n due to participant nonresponse for certain questions		
^Categories are not mutually exclusive		
*Other topics include PrEP (n=1) and why certain populations of gay community are more at risk (n=1)		

6.3.6 PARTNER SERVICES

Forty percent of persons at-risk for HIV in the DMA had heard of partner services for people with HIV/STIs. 31% of participants reported participating in HIV/STI partner services at some point. Of those who reported participating in partner services, 40% described their experience as “excellent”, 40% described their experience as “neutral” and 20% described their experience as “poor”. Please refer to section 6.2.2 for more information regarding client experiences with Partner Services.

6.3.7 HIV PREVENTION

In an open-ended question, participants were asked what they think is the most important thing someone can do to keep from getting HIV; the top qualitative themes elicited from participant responses is presented in table 133.

Table 133: Most important thing to prevent HIV among persons at-risk for HIV, DMA, 2015

DMA
1. Practice safe sex (i.e., use a condom)
2. Abstain from sex
3. Talk with sex partner(s) about HIV status
4. Have knowledge of HIV and education on prevention
5. Get tested

A. PrEP Knowledge and Attitudes

Table 134 presents participants' knowledge and attitudes regarding pre-exposure prophylaxis, or PrEP. Over two-thirds of at-risk surveyed in the DMA had either heard of an HIV prevention pill or had heard specifically about PrEP (68%), and 61% knew of someplace they could go to get PrEP. 85% of participants would consider taking PrEP if they and their doctor felt it was right for them and 90% would encourage an at-risk friend to take PrEP. 34% of participants knew someone currently using PrEP.

Table 134: PrEP knowledge & attitudes among persons at-risk for HIV/AIDS, DMA, 2015

Characteristic	DMA	
	n (n=41)**	%
Heard of Prevention Pill or PrEP		
Yes	27	68
No	13	33
Feel Comfortable Discussing PrEP with Doctor		
Yes	35	88
No	5	13
Would Consider Taking PrEP		
Yes	35	85
No	6	15
Why Wouldn't You Consider Taking PrEP^		
I don't think it is right for me	4	67
I worry about side effects	4	67
It is too expensive	2	33
Other*	1	17
I don't think it works	1	17
Someone might find out I am taking it	1	17
I am not at risk for HIV	1	17
I don't think it's safe	0	0
Encourage At-Risk Friend to Take PrEP		
I would	37	90
I would not	4	10
Know Anyone On PrEP		
Yes	14	34
No	27	66
Trust PrEP to Protect You from HIV		
Yes	29	73
No	11	28
Know Where to Get PrEP		
Yes	25	61
No	16	39

**Numbers may not add to total n due to participant nonresponse for certain questions

^Among those who said they would not consider taking PrEP

*Other reasons include 'I worry about taking medications like this' (n=1) and 'I prefer condoms' (n=1)

SECTION 6.3 SUMMARY: SURVEY AMONG PERSONS AT-RISK FOR HIV/AIDS IN THE DMA

- A total of 41 surveys were administered with persons at-risk for HIV in the DMA with participants from Wayne, Oakland and Macomb counties; organizations were asked to target recruitment efforts to persons at risk for HIV from specific groups (e.g., young black men who have sex with men, transgender individuals, injecting drug users, high risk heterosexuals, etc.).
- Just over half of participants were between the ages of 18 and 25 years, the majority were male, and just over half were black/African American.
- 49% identified as MSM and 21% identified as bisexual.
- Salary/wages were the primary forms of financial support for participants.
- Just over half of participants had private insurance, 40% were on Medicaid, Medicare, or the Healthy Michigan Plan.
- Just over a third of participants had experienced an unstable housing situation in the past 12 months.
- Nearly all had received an HIV test, most within the past year. Most were tested at a community HIV/STI testing site.
- The majority were tested because they were concerned after having unprotected sexual contact or they were receiving a routine HIV test.
- While 62% reported having been to a doctor in the past year for a non-emergency visit, only 35% were offered an HIV test.
- 84% of participants reported having had unprotected sexual contact with a non-monogamous partner; the most common risky behaviors engaged in by participants were oral sex (mouth-penis) and insertive anal sex without a condom.
- Most had received HIV/STI prevention education and over half received this education from a community based organization.
- Participants were most interested in learning about stress reduction, how to maintain a monogamous relationship, and skill building on how to reduce the spread of HIV/STIs.
- 68% participants had heard either heard of an HIV prevention pill or had specifically heard about PrEP; most felt comfortable discussing PrEP with their doctor and most would consider taking PrEP if they and their doctor felt it was right for them
- Among those who would not consider taking PrEP, the top reasons included not thinking PrEP was right for them, worrying about the side effects, and feeling that PrEP is too expensive.

SECTION 7: PROVIDERS IN THE DETROIT METROPOLITAN AREA

7.1. SURVEY OF PROFESSIONALS PROVIDING CARE AND SERVICES TO PERSONS LIVING WITH HIV/AIDS IN THE DMA

As part of the health systems assessment (see Section 1.1 Needs Assessment Process), we surveyed professionals throughout Michigan who provide care or services to persons living with HIV to gain a better understanding of how medical and service providers counsel or treat patients and of the barriers experienced while providing care or services to persons living with HIV/AIDS. Of particular interest to the HIV Planning Steering Committee was how the Affordable Care Act and Medicaid expansion impacted care and service delivery for persons living with HIV/AIDS in Michigan and the Detroit Metropolitan Area (DMA).

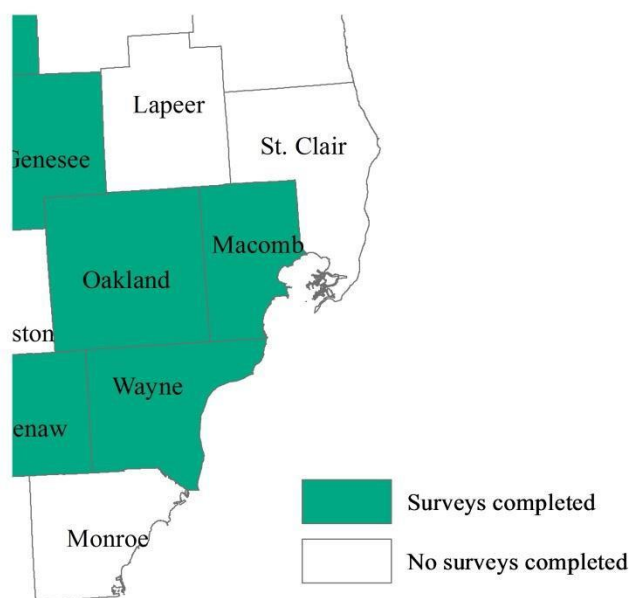
The survey was self-administered and respondents had the option to respond to an online version via Survey Monkey or a hard copy that was mailed to the provider office. The survey consisted of mostly multiple choice questions and took approximately 30 minutes to complete. Providers were not given an incentive for their time. Survey questions were reviewed by the Steering and Subcommittee for readability, consistency with survey goals, and for content. Survey topics included: provider demographics, providers comfort discussing HIV transmission and care, services routinely offered to patients or clients with HIV, how providers link persons living with HIV/AIDS to medical and support services, provider confidence in medical, dental, and support services offered to persons living with HIV/AIDS, antiretroviral medications that prevent HIV transmission, barriers to providing care or services, patient experiences, and current education needs. This survey is not representative of the DMA and does not include information on providers from St. Clair or Lapeer. Data from this survey should be used in addition to other secondary data sources. A copy of the survey tool can be found in the Appendix.

The research protocol, informed consent script, and survey tool were approved by the Institutional Review Board (IRB) at the Michigan Public Health Institute in Okemos, Michigan and the Michigan Department of Health and Human Services in Lansing, Michigan. Data from closed ended questions were analyzed using the Statistical Package for the Social Sciences (SPSS) and are presented using descriptive statistics.

A total of 159 professionals who provide care or services to persons living with HIV/AIDS throughout Michigan completed a survey. Of these, 57 (36%) provided care or services in the Detroit Metropolitan Area (DMA), which is comprised of Wayne, Oakland, Lapeer, Macomb, Monroe, and St. Clair counties. In this section, data will be presented for the DMA region of Michigan. Data for Michigan, which includes the DMA and Out State, and Out State only are presented in Section 4 of this document.

Figure 50 displays the counties in Michigan in which survey respondents provided care and services to PLWH. Of the 57 professionals who completed a survey in the DMA, 43 (75%) provided services in Wayne County, 12 (21%) provided care in Oakland County, and 3 (5%) provided services in Macomb County. One provider (2%) indicated that they worked throughout all counties in Michigan and thus considered to be part of the DMA (not depicted in Figure).

Figure 50: County of employment among medical professionals and service providers, DMA, 2015



7.1.1 INDIVIDUAL AND PROFESSIONAL DEMOGRAPHICS

Table 135 presents professional characteristics of the survey respondents. In the DMA, more than half of the survey respondents were nurses, nurse practitioners, or advanced practice nurses (53%), followed by social workers (12%), health educators (12%), administrators and program directors (12%), physicians/physician assistants (12%), and case managers (11%). The majority of professionals had worked in their field for 11 years or more (68%). Approximately 12% of professionals had worked for 6 to 10 years and 16% of professionals had worked in their field for 1 to 5 years. Four percent of respondents had worked in their field for less than 1 year. Twenty-four percent of professionals worked in community-based organizations (CBO), 18% of professionals worked in HIV clinical specialty care, 16% of professionals worked in a hospital setting, 9% worked in health departments, and 4% of professionals worked in a federally qualified health center or community health center (FQHC/CHC). Approximately 29% of professionals worked in other types of organizations which included pharmacies, correctional facilities, urgent cares, solo practices, domestic abuse shelters, sexual assault examiner programs, school-based clinics, and community mental health practices.

Table 135: Professional demographics among surveyed providers, DMA, 2015

Characteristic	n	%
Total	57	100
Profession[^]		
Nurse/NP/APRN	30	53
Social Worker	7	12
Health Educator	7	12
Administrator/Program Director/Manager	7	12
Physician/Physician Assistant	7	12
Case Manager	6	11
Other	4	7
Mental Health Provider	4	7
Clinical Pharmacist	2	4
Dentist/Dental Hygienist	1	2
Experience		
Less than 1 year	2	4
1-5 years	9	16
6-10 years	7	12
11+ years	39	68
Organization Type		
Other	16	29
CBO	13	24
HIV clinical specialty care	10	18
Hospital	9	16
Health Department	5	9
FQHC/CHC	2	4
[^] Categories were not mutually exclusive		
Nurse/NP/APRN = Nurse/Nurse Practitioner/Advanced Practice Nurse; CBO =		
Community-based organization; FQHC/CHC = Federally Qualified Health		
Center/Community Health Center		

Table 136 presents the individual demographic characteristics of the survey respondents. Seventy-seven percent of the survey respondents were women, 21% were men, and 2% were transgender. The majority of professionals were White (63%), 33% were Black, and 4% were Asian. Two percent of survey respondents were Hispanic/Latino and 4% were Arab/Chaldean. The majority of professionals identified themselves as heterosexual (88%). Twelve percent of professionals self-identified as men who had sex with men and 6% of respondents self-identified as Queer.

Table 136: Individual demographics among surveyed providers, DMA, 2015

Characteristic	n	%
Total	57	100
Gender		
Male	12	21
Female	44	77
Transgender	1	2
Race[^]		
White	36	63
Black/African American	19	33
Asian	2	4
Multiracial	0	0
American Indian/Alaska Native	0	0
Other	0	0
Ethnicity		
Hispanic/Latino	1	2
Arab/Chaldean	2	4
None of the above	47	94
Sexual Identity		
Heterosexual/Straight	46	88
MSM/Gay	6	12
Queer	3	6
[^] Categories were not mutually exclusive; MSM=men who have sex with men		

In the DMA, the median number of clients with HIV infection that professionals provided care or services for in the past 5 days was 20, with a range of 0 to 200 patients (Table 137). Thirty-eight percent of professionals had more than 50% of their client population consisting of PLWH and 42% of professionals had less than 10% of their client population consisting of PLWH.

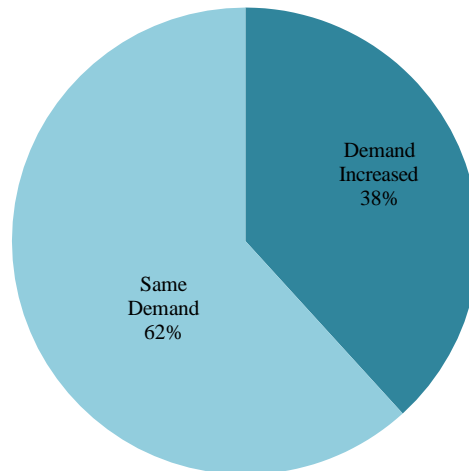
Table 137: Clients with HIV infection, DMA, 2015

	n	%
Proportion of Clients who are HIV+		
Less than 10%	22	42
11-25%	7	13
26-50%	4	8
More than 50%	20	38
Number of Clients with HIV Receiving care/Services in Past 5 Days		
Mean	34	
Median	20	
Range	0 to 200	

7.1.2 IMPACT OF THE AFFORDABLE CARE ACT AND MEDICAID EXPANSION IN THE DMA

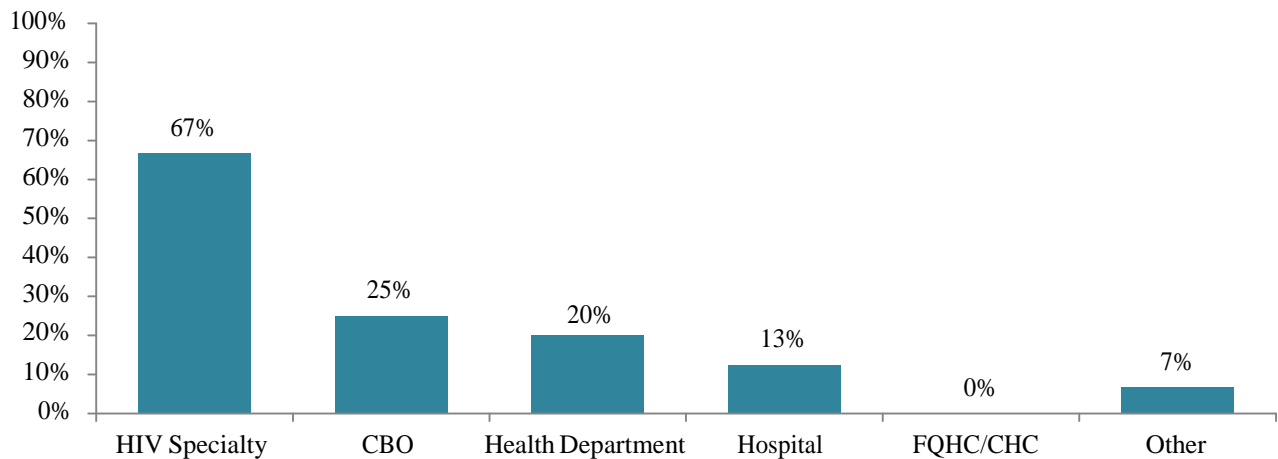
When asked how the demand for services has changed among persons living with HIV since the implementation of the Healthy Michigan Plan and Medicaid expansion, 38% of professionals said that demand increased, 62% of professionals said that the demand stayed the same, and 0% of professionals said the demand decreased (Figure 51).

Figure 51: Demand for services since the implementation of the Healthy Michigan Plan/Medicaid Expansion, DMA, 2015



A greater percentage of professionals representing HIV clinical specialty care organizations (67%) experienced an increase in demand for services compared to other organization types. In the DMA, 25% of professionals representing CBOs, 20% of professionals representing health departments, 13% of professionals representing hospitals, and 7% of professionals representing other organizations experienced an increased demand in services (Figure 52).

Figure 52: Experienced an increase in demand for services since the implementation of the Healthy Michigan Plan/Medicaid Expansion by organization type, DMA, 2015



Approximately 35% of professionals in the DMA have experienced burdens due to the implementation of the Affordable Care Act and Medicaid Expansion (Table 138). Of these, a greater percentage of professionals working in Hospitals (71%) have experienced burdens compared to professionals from other organization types. Fifty percent of professionals representing HIV clinical specialty care, 40% of professionals representing health departments, 25% of professionals representing CBOs, and 21% of other organizations reported experiencing burdens.

Table 138: Experienced burdens due to the implementation of the Affordable Care Act or Medicaid Expansion, DMA, 2015

	Yes, Experienced Burdens	Total orgs	
	n	n	%
HIV Specialty	4	8	50
CBO	3	12	25
Health Department	2	5	40
Hospital	5	7	71
FQHC/CHC	0	2	0
Other	3	14	21
Total	17	48	35

CBO = Community-based organization; FQHC/CHC = Federally Qualified Health Center/Community Health Center

A follow up question to those who experienced burdens was to describe the burdens experienced due to the implementation of the Affordable Care Act and Medicaid expansion. The most frequent theme identified related to having an increased workload. Many respondents said that the increased workload

was due to an increased patient/client volume and also due to an increase in the amount of time and paperwork involved to assist patients/clients in getting health coverage. Having clients unexpectedly lose insurance or experience lapses in coverage was identified as another burden. Some responses noted that the cause for insurance termination was system or human error. For example, one professional mentioned that they have had several clients lose health coverage when the Insurance Premium Assistance Program (IPAP) failed to pay the premiums. Another professional noted that a client's Medicaid coverage was terminated due to failure to complete a health questionnaire. Some professionals stated that costs to provide services to clients were greater than reimbursement rates. A few professionals spoke of the infrastructure in itself being too complicated and frustrating. The inability to get certain coverage assistance and having patients assigned to HMOs out of service range, forcing patients to seek care elsewhere or wait to be seen until they are able to change insurance were a couple of issues that were also noted as problematic. Having the capacity to accommodate the increased volume of patients was mentioned by a one respondent as a burden experienced. Table 139 presents, in rank order, the top themes identified among participant responses regarding the burdens they have experienced since the Affordable Care Act and Medicaid expansion.

Table 139: Description of burdens experienced due to the implementation of the Affordable Care Act or Medicaid Expansion, DMA, 2015

1. There is an increased workload due to increased patient/client volume and increased complexity to accessing insurance
2. Patients/clients are losing their insurance coverage unexpectedly/lapses in coverage
3. Cost - low reimbursement rates
4. Infrastructure can be frustrating/confusing
5. Not having the capacity to accommodate increased volume

7.1.3 COMFORT WITH SERVICE PROVISION

A. Comfort Discussing HIV Transmission and Care

Forty-six individuals (81%) indicated that they did discuss topics related to HIV transmission with their patient/clients. Of these, the most of the professionals (88%) were 'very comfortable' discussing HIV transmission with a vast majority of population groups in the DMA (Table 140). The population groups that had the least number of professionals 'very comfortable' discussing HIV transmission were persons with limited English proficiency and children ages 0 to 12 years.

**Table 140: Professionals ‘very comfortable’ discussing HIV transmission with client population groups, DMA,
2015**

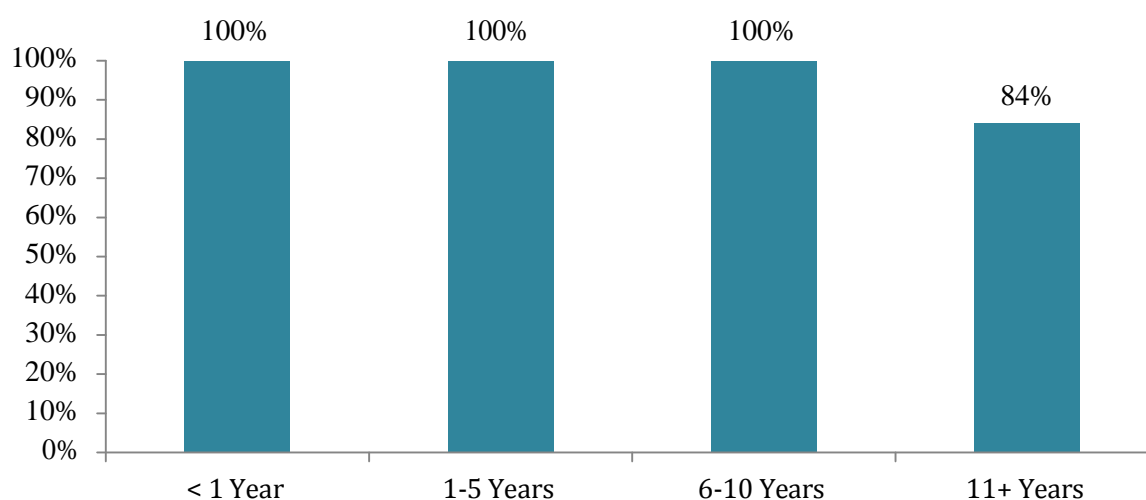
	n	%
Persons Living with HIV	40	91
Men Who Have Sex with Men	41	93
Substance User/Chemical Dependents	38	86
Medicaid Eligible	38	86
Racial/Ethnic Minorities	40	89
Men	41	95
Women	40	91
Adolescents (13-19 years)	35	90
Children (0-12 years)	12	43
Transgender	33	77
Sex Workers	38	88
Persons with Limited English Proficiency	17	44
Professionals who indicated that they did not interact with a population were excluded from the analysis		

Table 141 displays comfort discussing HIV transmission by organization type. Comfort discussing HIV transmission varied by organization type and population group and no single organization type consistently fared better than another. Professionals with less experience in their field were slightly more comfortable discussing HIV transmission than professionals with more than eleven years of experience (Figure 53).

Table 141: Professionals ‘very comfortable’ discussing HIV transmission with client populations by organization type, DMA, 2015

	HIV Specialty %	CBO %	Health Dept. %	Hospital %	FQHC/C HC %	Other %
Persons Living with HIV	100	92	100	80	50	100
Men Who Have Sex with Men	100	100	100	80	50	100
Substance User/Chemical Dependents	100	75	100	100	50	91
Medicaid Eligible	78	100	100	80	50	91
Racial/Ethnic Minorities	89	92	100	80	50	100
Men	100	100	100	100	50	100
Women	100	83	100	100	50	100
Adolescents (13-19 years)	100	90	100	80	0	100
Children (0-12 years)	50	50	20	100	--	43
Transgender	78	82	80	75	50	82
Sex Workers	88	92	100	75	50	100
Persons with Limited English Proficiency	33	80	60	50	0	20
Professionals who indicated that they did not interact with a population were excluded from the analysis						

Figure 53: Professionals ‘very comfortable’ discussing HIV transmission with client populations by experience, DMA, 2015



Forty-five respondents (79%) indicated that they did discuss topics related to HIV care with their patient/clients. Of these, most professionals were ‘very comfortable’ discussing HIV care with a vast majority of population groups (Table 142). Persons with limited English proficiency and children ages 0 to 12 were the population groups that had the least number of professionals ‘very comfortable’ discussing HIV care. Table 143 displays comfort discussing HIV care by organization type. Comfort discussing HIV care varied by organization type and population group, however, more professionals representing HIV clinical specialty care were ‘very comfortable’ discussing HIV care than professionals representing other organization types. Professionals with less experience in their field were slightly more comfortable discussing HIV care than professionals with more experience (Figure 54).

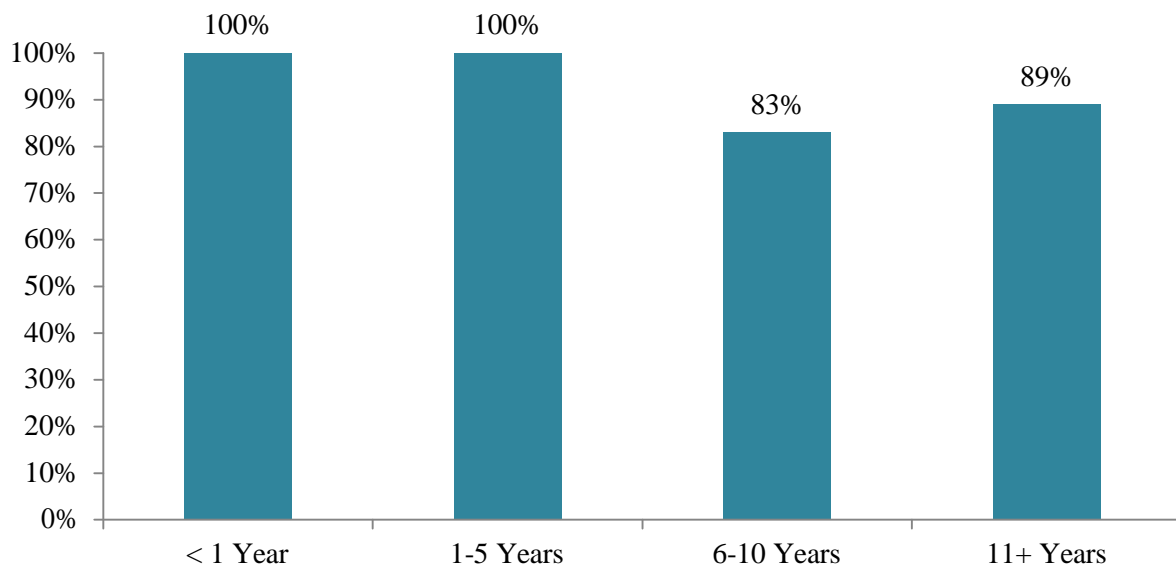
Table 142: Professionals ‘very comfortable’ discussing HIV care with client population groups, DMA, 2015

	n	%
Persons Living with HIV	38	84
Men Who Have Sex with Men	38	86
Substance User/Chemical Dependents	39	87
Medicaid Eligible	37	82
Racial/Ethnic Minorities	40	89
Men	39	89
Women	40	89
Adolescents (13-19 years)	30	79
Children (0-12 years)	10	40
Transgender	34	77
Persons with Limited English Proficiency	20	48
Professionals who indicated that they did not interact with a population were excluded from the analysis		

Table 143: Professionals ‘very comfortable’ discussing HIV Care with client populations by organization type, DMA, 2015

	HIV Specialty %	CBO %	Health Dept. %	Hospital %	FQHC/C HC %	Other %
Persons Living with HIV	100	91	100	100	50	75
Men Who Have Sex with Men	100	91	100	100	50	82
Substance User/Chemical Dependents	100	91	100	100	50	83
Medicaid Eligible	89	91	100	100	0	83
Racial/Ethnic Minorities	100	91	100	100	50	92
Men	100	91	100	100	50	91
Women	100	91	100	100	50	92
Adolescents (13-19 years)	100	67	100	75	0	80
Children (0-12 years)	57	20	25	--	--	50
Transgender	89	91	80	100	50	64
Persons with Limited English Proficiency	56	82	60	50	0	18
Professionals who indicated that they did not interact with a population were excluded from the analysis						

Figure 54: Professionals ‘very comfortable’ discussing HIV care with client populations by experience, DMA, 2015



B. Providing Medical Care

Professionals were very confident in the provision of most services offered to PLWH, but not all (Table 144). Nearly 90% of professionals were 'very confident' in communicating HIV risk and transmission, followed by providing long-term HIV care (74%), assessing patient/client sexual risk (69%), assessing when to begin therapy (68%), providing evidence-based individual HIV prevention interventions (67%), and assessing adherence to drug regimens (67%). However, only 20% of professionals surveyed were 'very confident' in treating chronic hepatitis and 48% of professionals were 'very confident' providing general care unrelated to HIV.

Table 144: Professionals 'very confident' providing services to persons living with HIV/AIDS, DMA, 2015

	n	%
Communicating HIV risk and transmission	32	89
Providing long-term HIV care	14	74
Assessing patient/client sexual risk	25	69
Assessing when to begin therapy	13	68
Providing evidence-based individual HIV prevention interventions	24	67
Assessing patient adherence to drug regimens	20	67
Managing ART adverse effects	12	63
Providing dental screening and care	8	62
Providing evidence-based group HIV prevention interventions	16	57
Remaining up-to-date with advances in HIV care	18	56
Assessing patient/client substance use/abuse	18	55
Providing general medical care unrelated to HIV	11	48
Treating chronic hepatitis	3	20
Professionals who indicated that they did not provide the service were excluded from the analysis		

Table 145 displays confidence in providing services to PLWH by organization type. Confidence in providing services varied by organization type and population group and no single organization type consistently fared better than another.

Table 145: Professionals ‘very confident’ providing services to persons living with HIV/AIDS by organization type, DMA, 2015

	HIV Specialty %	CBO %	Health Dept. %	Hospital %	FQHC/C HC %	Other %
Communicating HIV risk and transmission	100	100	100	100	50	80
Assessing patient/client substance use/abuse	71	60	50	60	50	50
Assessing patient/client sexual risk	88	86	100	60	50	60
Providing evidence-based group HIV prevention interventions	71	50	100	33	0	83
Providing evidence-based individual HIV prevention interventions	75	86	100	50	0	73
Providing dental screening and care	100	100	0	--	50	57
Providing long-term HIV care	100	0	--	67	0	71
Providing general medical care unrelated to HIV	100	50	--	0	0	56
Treating chronic hepatitis	0	--	--	0	0	43
Assessing when to begin therapy	80	0	--	100	0	75
Managing ART adverse effects	75	0	--	100	0	56
Assessing patient adherence to drug regimens	86	86	86	86	86	86
Remaining up-to-date with advances in HIV care	75	50	50	100	0	55
Professionals who indicated that they did not provide the service were excluded from the analysis						

7.1.4 ORGANIZATIONAL TESTING AND PARTNER SERVICES

Forty professionals (70%) indicated that their organization did conduct HIV tests. All professionals for HIV clinical specialty care and Health Departments indicated that their organizations did conduct testing (Figure 55). Most professionals representing hospitals (86%) stated that their organization conducted HIV testing. Seventy-five percent of professionals representing CBOs, 62% of other organizations, and 50% of FQHC/CHC indicated that their organization conducted HIV testing. Sixty-three percent of professionals said that their organization routinely offered testing to all individuals, 32% of professionals said that their organization conducted targeted testing only, and 5% of professionals said that their organization only conducted testing when there were clinical signs or symptoms of HIV infection (Figure 56).

Figure 55: Organization conducts HIV testing by organization type, DMA, 2015

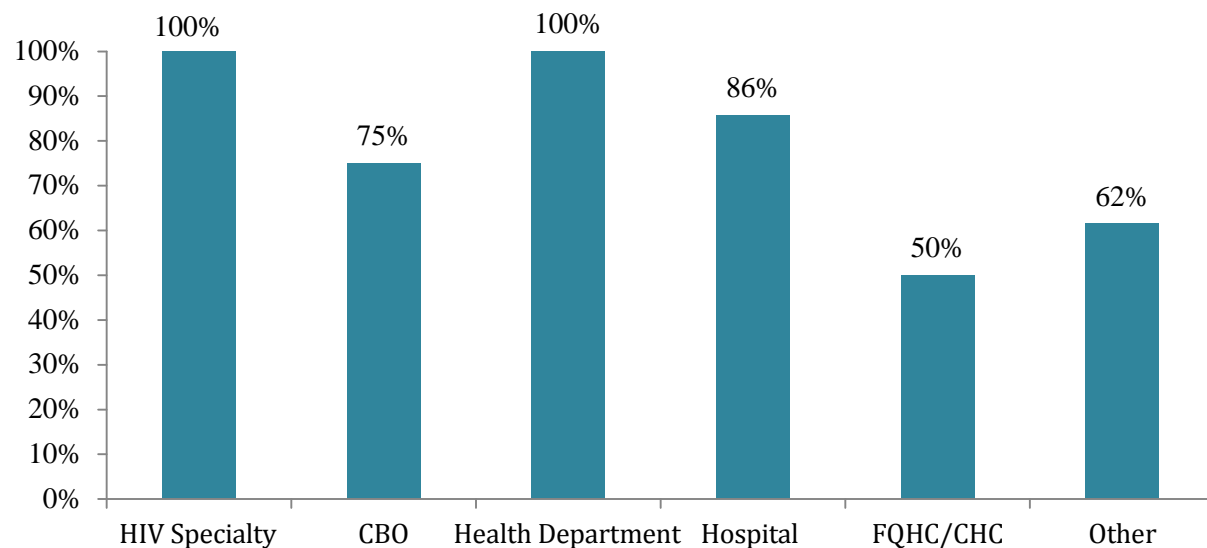
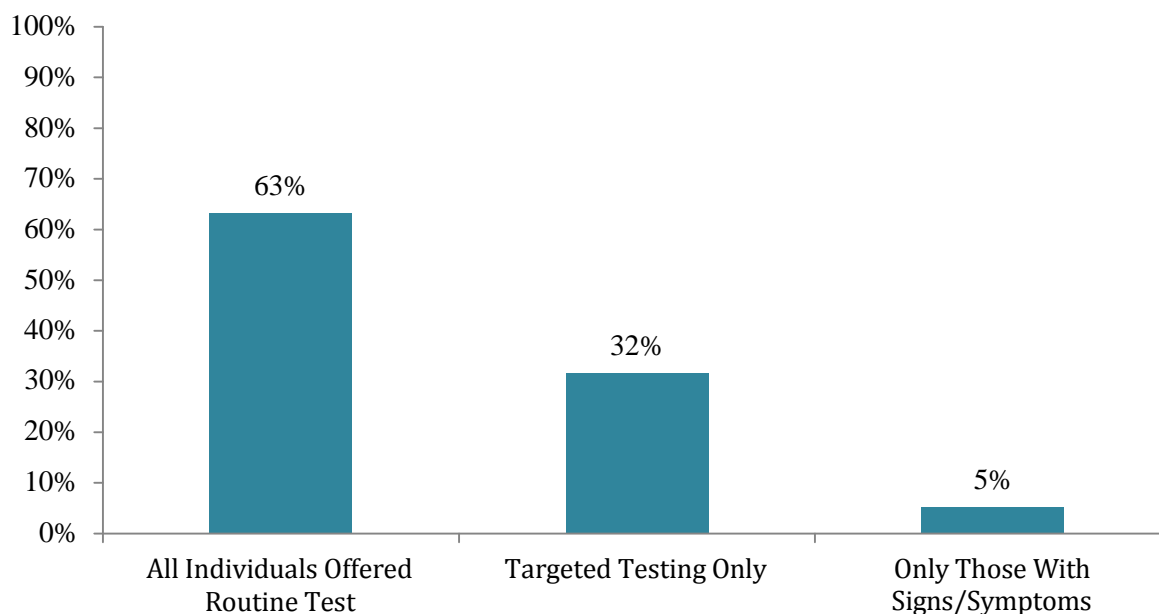


Figure 56: When HIV tests are conducted, DMA, 2015



Professionals were asked to choose from a list of barriers which they thought were they most significant to offering testing for HIV. The most significant barriers was 'patients/clients do not want to be tested' (Table 146). Other significant barriers include 'our patients/clients don't view HIV as a pressing issue' (21%) and 'reimbursement for HIV testing is low or unavailable' (15%). There was an option for professionals to add barriers that were not listed as an 'other, please specify' choice. The common barriers mentioned by professionals were related to client attitudes or behaviors. Stigma, fear, and client concern about confidentiality were commonly cited. Other barriers mentioned were a lack of human and financial resources, patients' partners refusing testing, lack of staff training, and the difficulty of identifying targeted risk groups.

Table 146: Barriers that organization faces when offering HIV tests, DMA, 2015

	n	%
Our patients/clients do not want to be tested	12	36
Other*	11	33
We have no barriers	8	24
Our patient/clients don't view HIV as a pressing issue	7	21
Reimbursement for HIV testing is low or unavailable	5	15
There isn't enough time during the visit to provide HIV testing	2	6
Our providers don't view HIV as a pressing issue for our patients/clients	2	6
Our providers are uncomfortable discussing HIV with patients/clients	1	3
Total^	33	

^Categories are not mutually exclusive

*Other includes: Clients' fear/stigma/concern about confidentiality, lack of resources (human and monetary), partners refuse testing, identification of targeted risk group, missed appointment for infant testing, obtaining test kits

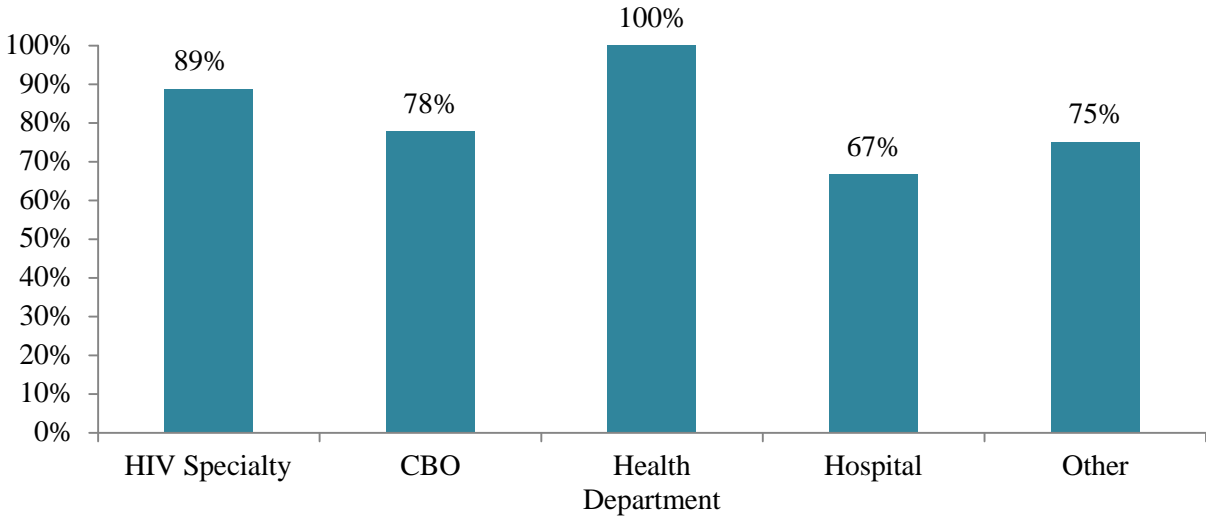
A. Partner Services

Over 80% of organizations that conducted HIV testing collected partner information to offer or refer clients to partner services; 36% of organizations collected information and offered partner services and 49% collected information and referred out to partner services (Table 147). Of the organizations that conducted HIV tests, 79% did have a plan in place to ensure at-risk partners were notified and tested. All professionals representing health departments indicated their organization had a plan in place to notify and test at-risk partners (Figure 57). Eighty-nine percent of professionals from HIV clinical specialty care said their organization had a plan in place, followed by 75% of professional representing CBOs, 75% professional representing other organizations, and 67% representing hospitals.

Table 147: Partner services among organizations that conduct HIV testing, DMA, 2015

	n	%
Collect partner information for partner services when client test positive for HIV		
Yes and offer partner services	14	36
Yes and refer out for partner services	19	49
Do not collect partner services information	6	15
Organization has a plan in place to ensure at-risk partners are notified and tested		
Yes	31	79
No	8	21

Figure 57: Organization has a plan in place to ensure at-risk partners are notified and tested by organization type, DMA, 2015



7.1.5 ORGANIZATIONAL BARRIERS

Professionals were asked to choose from a list of organizational barriers which they thought were most significant barriers to providing medical, dental, or support services to PLWH. The most significant organizational barrier was 'insurance coverage concerns' (Table 148). Other barriers included 'lack of staff time to provide services', 'limited reimbursement for services', and 'lack of available providers proficient in the provision of HIV care'.

Table 148: Organizational barriers to providing medical, dental, or support services to persons living with HIV/AIDS, DMA, 2015

	n	%
Insurance coverage concerns	16	48
Lack of staff time to provide services	12	36
Limited reimbursement for services	9	27
Prior authorization concerns	8	24
Other*	6	18
Lack of available providers proficient in the provision of HIV care	5	15
Formulary restrictions	4	12
Lack of referral partners for services not offered in our organization	3	9
Lack of cultural competency when communicating with patients	3	9
Sigma or avoidance of HIV issues among staff	1	3
Fail-first or step therapy concerns	1	3
Quantity limits	1	3
Total^	33	
^Categories are not mutually exclusive		
*Other includes: lack of patient transportation, no shows, stigma external to our department, inability to follow through and adhere to treatment/service plan, list of low cost resources		

Professionals were asked to choose from a list of organizational barriers which they thought were the most significant barriers to linking patients/clients to HIV medical care. The most significant organizational barrier was 'patient/client resistance' (Table 149). Other common barriers include 'limited amount of dedicated funding', 'limited staff knowledge/skills/experience', 'difficult to get clients into specialty care', and 'limited staff time'. There was an option for professionals to add barriers that were not listed as an 'other, please specify' choice. The common barriers cited by professionals were lack of transportation, don't always have soon enough appointments for newly diagnosed patients, difficult to ensure continuity of care once released, linking to outside providers.

Table 149: Organizational barriers to linking patients with HIV to medical care, DMA, 2015

	n	%
Patient/client resistance	16	32
Limited amount of dedicated funding	9	18
Limited staff knowledge/skills/experience	9	18
Difficult to get clients into specialty care	7	14
Limited staff time	7	14
Other	7	14
Inability to be reimbursed for linkage services	5	10
We do not encounter barriers	4	8
No established procedure or protocol in place	4	8
Staff resistance to providing this service	4	8
Unsure where to refer patients/clients	4	8
Staff cultural competency/comfort with issue	3	6
Services are not available in our area	2	4
Leadership resistance to providing this service	2	4
Total^	50	
^Categories are not mutually exclusive		
Other includes: lack of transportation, don't always have soon enough appointments for newly diagnosed patients, difficult to ensure continuity of care once released, linking to outside providers		

7.1.6 LINKAGES AND REFERRALS TO MEDICAL CARE

Of professionals whose organizations facilitate linkage to medical care, nearly all (91%) provide referrals to specific providers (Table 150). Other common ways PLWH were linked to medical care include scheduling appointments for patients/clients (82%), providing patients/clients with a list of local providers (68%), providing early intervention services or other specific linkages (55%), and accompanying patients/clients to appointments (55%). Providing case management services was cited by 45% of professionals and providing transportation assistance was cited by 41% of professionals.

Of professionals whose organizations facilitate linkage to support services, most (83%) provided referrals to specific providers. Other common ways PLWH were linked to support services included referring patients/clients internally to care (76%), scheduling appointment for patients/clients (67%), and providing patients/clients with a list of local providers/services (61%). Providing case management services was cited by 43% of professionals and providing transportation assistance was cited by 28% of professionals as ways clients were linked to support services.

Table150: Linkage of HIV positive patients to medical care and support services, DMA, 2015

	n	%
Linkage to Medical Care		
Provide referrals to specific providers	20	91
Schedule appointment for patients/clients	18	82
Provide patients/clients with a list of local providers/services	15	68
Provide early intervention services or other specific linkages	12	55
Accompany patients/clients to appointments	12	55
Confirm that the patient/client attended the appointment	11	50
Provide reminders about the upcoming appointments	10	45
Provide case management services	10	45
Provide transportation assistance	9	41
Provide translation services	8	36
Refer patients/clients internally to care	6	27
Other	1	5
Total^	22	
Linkage to Support Services		
Provide referrals to specific providers	38	83
Refer patients/clients internally to care	35	76
Schedule appointment for patients/clients	31	67
Provide patients/clients with a list of local providers/services	28	61
Provide early intervention services or other specific linkages	20	43
Provide case management services	20	43
Confirm that the patient/client attended the appointment	19	41
Provide reminders about the upcoming appointments	15	33
Provide transportation assistance	13	28
Provide translation services	13	28
Accompany patients/clients to appointments	12	26
Other	3	7
Total^	46	
^Categories are not mutually exclusive		

7.1.7 PROVIDER PERSPECTIVES ON PATIENT EXPERIENCES

Thirty-eight percent of professionals said that their organizations had no wait times for appointments for new patients with HIV (Figure 58). Approximately 33% of professionals said that the wait time for new patients with HIV was less than one week, 18% of professionals said the wait times were 1 to 2 weeks, and 10% of professionals said the wait times were more than 3 weeks. A greater percentage of health departments, CBOs, and HIV clinical specialty care organization types had appointment wait times that were less than one week compared to other organization types (Figure 59). Professionals were asked to choose from a list of barriers they considered the most significant for patients/clients with HIV seeking services from their organization (Table 151). Transportation was noted as the most significant patient barrier by 53% of professionals. Other barriers noted were mental illness (40%), patient/client non-compliance (36%), substance abuse (30%), and HIV stigma (26%).

Figure 58: Appointment wait time for new patients with HIV, DMA, 2015

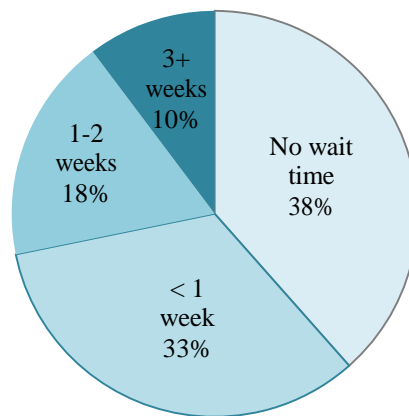


Figure 59: Appointment wait times that are less than one week for new patients with HIV by organization type, DMA, 2015

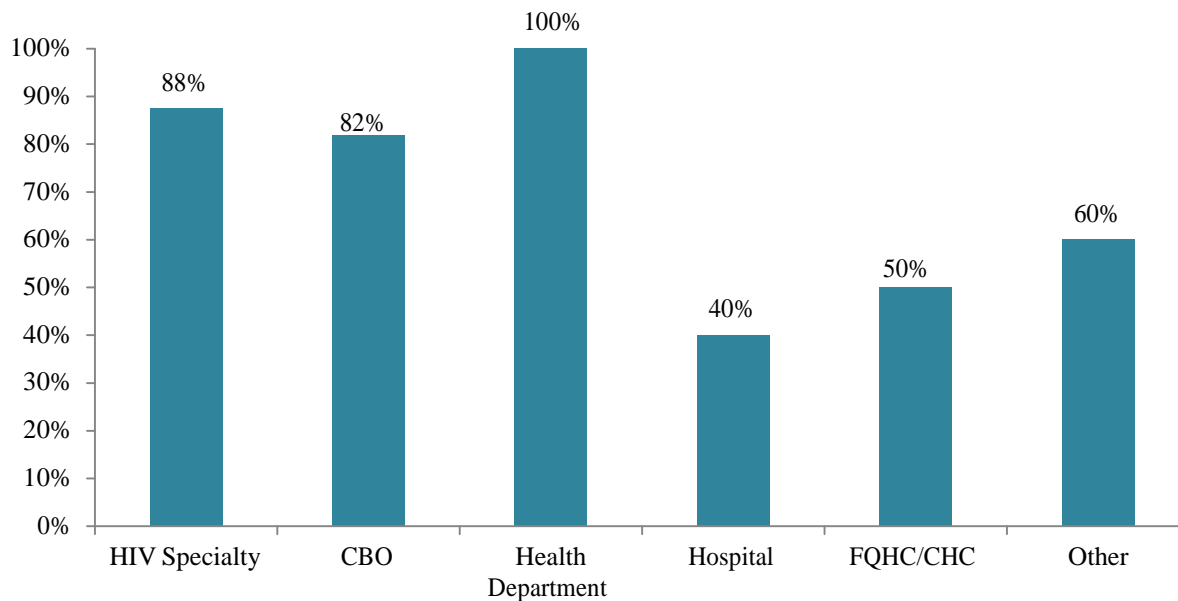


Table 151: Provider perspectives on barriers for patients seeking HIV care or services, DMA, 2015

	n	%
Transportation issues	25	53
Mental illness	19	40
Patient/client non-compliance	17	36
Substance abuse	14	30
HIV stigma	12	26
Other	5	11
Ability to pay	4	9
Housing insecurity	4	9
Location of HIV treatment centers	2	4
Childcare	2	4
Lack of provider sensitivity to client/patient gender identity	1	2
Total^	47	

^Categories are not mutually exclusive

7.1.8 MEDICATION PRACTICES

A. Prescription of Pre-Exposure and Post-Exposure Prophylaxis

Of survey respondents, 30% indicated that they did prescribe medications that prevent HIV infection or treat current HIV infections (Table 152). Of these, 50% had ever prescribed continuous daily dosing of Truvada for pre-exposure prophylaxis (PrEP) of HIV infection and 50% had ever prescribed antiretroviral medication for non-occupational post-exposure prophylaxis (nPEP). Eighty-six percent of providers prescribed PrEP to women who have sex with men, 71% prescribed PrEP for men who have sex with men, and 57% of providers prescribed PrEP for uninfected partners in serodiscordant couples attempting to conceive. All providers prescribed nPEP for survivors of sexual assault, 71% of providers prescribed nPEP for women who have sex with men, 57% of providers prescribed nPEP for men who have sex with men, and 43% of providers prescribed nPEP for men who have sex with women.

Table 152: Prescription of Pre-Exposure Prophylaxis (PrEP) and Post-Exposure Prophylaxis (nPEP), DMA, 2015

	n	%
Prescribe patients medications that prevent or treat HIV infection		
Yes	14	30
No	33	70
Ever prescribed continuous daily dosing of tenofovir/emtricitabine (Truvada) for pre-exposure prophylaxis (PrEP) of HIV infection		
Yes	7	50
No	7	50
For whom have you prescribed continuous daily dosing of tenofovir/emtricitabine (Truvada) for PrEP		
Women who have sex with men	6	86
Men who have sex with men	5	71
Uninfected partners in serodiscordant couples trying to conceive	4	57
Men who have sex with women	3	43
Sex workers	3	43
Other*	2	29
Transgender women	2	29
Transgender men	1	14
Injecting drug users	1	14
Total^	7	
Ever prescribed antiretroviral medication for non-occupational post-exposure prophylaxis (nPEP)		
Yes	7	50
No	7	50
For whom have you prescribed antiretroviral medication for nPEP?		
Survivors of sexual assault	7	100
Women who have sex with men	5	71
Men who have sex with men	4	57
Men who have sex with women	3	43
Transgender women	2	29
Sex workers	1	14
Transgender men	1	14
Total^	7	
^Categories are not mutually exclusive		

B. Opioid Safety

Providers were given a series of statements and asked to indicate their personal perspective on barriers to implementing opioid safety training with naloxone for HIV positive patients and patients considered at-risk for HIV infection (Table 153). Fifty-five percent of providers did indicate that their patients received prescriptions for opioids and/or were at risk of overdose. The majority of providers were comfortable discussing opioid safety with their patients (84%). However, there was a lack of awareness of the programs available to providers. Sixty-one percent of professionals disagreed or did not know about screening tools for overdose risk and 67% of professionals disagreed or did not know about programming to address opioid overdose. Concerns about costs (67%) and concerns about patients discussing opioid use honestly (68%) were additional barriers identified.

Table 153: Professional awareness and beliefs on opioid safety training with Naloxone for HIV positive patients and patients at-risk for HIV infection, DMA, 2015

	n	%
I am concerned about costs and reimbursement for training and access to naloxone rescue kits		
Agree	6	67
Disagree	3	33
My patients do not receive prescriptions for opioids and/or are not at risk of overdose		
Agree	10	45
Disagree	12	55
I am aware of screening tools for overdose risk		
Agree	11	39
Disagree/Don't Know	17	61
I am aware of programming to address opioid overdose		
Agree	9	33
Disagree/Don't Know	18	67
I am comfortable discussing opioid use and possible substance abuse with my patients		
Agree	27	84
Disagree	5	16
I am concerned my patients won't discuss opioid use and other substance use honestly with me		
Agree	21	68
Disagree	10	32
Professionals who indicated that the statement was not applicable to their practice and those who responded 'Don't Know' were excluded from the analysis unless otherwise indicated		

7.1.9 EDUCATIONAL TOPICS OF INTEREST

Table 154 presents a list of the educational topics of interest to professionals who provide care or support services to patients/clients with HIV. When asked about education needs, providers indicated that management of co-infections, sexual health behavioral assessments, retention in care, PrEP/nPEP, mental health care, LGBTQ sensitivity training, antiretroviral therapy, diagnosis and treatment for opportunistic infections, opioid therapy, and HIV prevention counseling were the top ten topics of interests.

Table 154: Educational topics of interest among professionals who provide care or support services to patients with HIV, DMA, 2015

	n	%
Management of co-infections	20	44
Sexual health behavioral assessments	19	42
Retention in care	18	40
PrEP/nPEP	18	40
Mental health care	15	33
LGBTQ sensitivity training	15	33
Antiretroviral therapy	15	33
Diagnosis and treatment for opportunistic infections	14	31
Opioid substitution therapy	12	27
HIV prevention counseling	9	20
HIV treatment education	8	18
HIV rapid testing	5	11
STI screening and treatment	4	9
Other	4	9
Total^	45	

^Categories are not mutually exclusive
Other includes: motivational interviewing, services and support services available, smoking cessation, stigma management, tobacco and HIV, transgender specific care needs, always want more knowledge seminars

SECTION 7.1 SUMMARY: SURVEY OF PROFESSIONALS WHO PROVIDE CARE AND SERVICES TO PERSONS LIVING WITH HIV IN THE DMA

- In 2015, a self-administered online survey was completed by 57 medical and service providers in the DMA. Seventy-five percent of respondents were from Wayne County, 21% of from Oakland County, and 5% were from Macomb County.
- Over half of respondents were nurses and nearly 70% of respondents had 11 years or more experience in their field.
- The majority of respondents were female, White, and heterosexual. Twenty-one percent of respondents were Black/African American and 4% were Asian. Twelve percent of respondents identified as men who have sex with men.
- Since the implementation of the Healthy Michigan Plan and Medicaid expansion, 38% of providers said that demand for services increased and 62% of providers said demand stayed the same.
- Approximately 35% of professional in the DMA experienced burdens due to the implementation of the Affordable Care Act and Medicaid expansion. The greatest burdens identified were an increased workload due to increased volume of patients and an increased time and complexity to accessing insurance and having clients unexpectedly lose insurance.
- Professionals were very confident in the provision of most services offered to PLWH, but not all. Less than half of professionals surveyed were 'very confident' in providing dental screening and care to PLWH and only 20% of professionals were 'very confident' in treating chronic hepatitis.
- The most commonly cited organizational barrier to testing was that patients/clients do not want to be tested.
- Over 80% of organizations that conducted HIV testing collected partner information to offer or refer clients to partner services; 36% of organizations collected information and offered partner services and 49% collected information and referred out to partner services. The majority of organizations that conduct HIV tests do have a plan or protocol in place to ensure at-risk partners are notified and tested.
- The most common organizational barrier to providing medical care and support services was insurance coverage concerns.
- The most common organizational barrier to linking patients with HIV to medical care was patient/client resistance.
- Providing referrals to specific providers was the most frequently cited method of linking patients to medical care and to linking to support services.
- Thirty-eight percent of professionals said that their organizations had no wait times for appointments for new patients with HIV. However, 10% said wait times were more than 3 weeks.
- Providers cited transportation, mental illness, patient/client non-compliance, and substance abuse as the most significant barriers to patients seeking HIV care or services.
- More than half of providers did indicate that their patients received prescriptions for opioids and/or were at risk of overdose. The majority of providers were comfortable discussing opioid safety with their patients. However, there was a lack of awareness of the programs and tools available to providers to address opioid overdose.

7.2 DETROIT METRO AREA (DMA) JAIL HIV EVALUATION

A formative evaluation to obtain information on HIV testing and care processes in Michigan county jails was conducted between May 2015 and August 2015. Based on convenience sampling, a semi structured interview was administered to Local Health Department (LHD) staff, who have some sort of relationship with the jails in five high incidence counties in the following prosperity regions (PR); 10, 9, 6, and 4. Phone interviews lasting approximately 30 minutes were completed. When recommended, staff from partnering Community Based Organizations (CBOs) were also contacted and interviewed. As such, a few additional interviews were conducted with CBO staff in prosperity regions 10 and 6. Data that was collected is provided to establish a picture of the current state of Michigan jails' processes in working with persons living with HIV. This is not a complete representation of all Michigan jails and cannot be generalized to all county jails. This interview was the first step in evaluating HIV testing and care procedures within county jails as well as their linkage to care once they are released. Findings will provide baseline data for more in-depth data collection for additional evaluation projects. To ensure confidentiality the jails in the DMA will be denoted as such: Jail A and Jail B.

7.2.1 HIV TESTING

Jail A has any individual who has never been tested and individuals who meet high-risk behavior criteria tested through the partnering University. Jail B conducts all HIV testing due to health department staff not being allowed to bring in sharps.

7.2.2 PROCESS OF WORKING WITH HIV POSITIVE INDIVIDUALS

In Jail A, a local CBO comes in once a week to work with HIV positive individuals. They begin working with incarcerated individuals before they are released, and continue that relationship after they have been released into their respective jurisdiction. The university also provides counseling services. In Jail B medical regiments are continued by non-ID physicians. An ID physician only sees patients when their CD4 count is below a certain level. All other services are provided after the individual is released by a local health service agency if they are contacted.

7.2.3 PROCESS OF WORKING WITH NEWLY DIAGNOSED INDIVIDUALS

In Jail A, the CBO provides case management after a client is diagnosed as HIV positive. Case managers come into the jail and establish a working file. The CBO only coordinates social services that the jail social service employees have not. They assist with these services once a client is released. This strategy alleviates issues experienced when a client is released without staff knowing. Individuals who reside in a different jurisdiction continue working with a case manager and the CBO acts as a liaison. In jail B they contact the health department when an individual is diagnosed with HIV, however this has only occurred twice in the past 6 months.

7.4.4 ACCESS TO HIV MEDICATIONS WHILE INCARCERATED AND PROTOCOL UPON RELEASE

Jail A provides medications throughout incarceration period and provides a 2 week supply upon release. If an individual is released without staff knowing, the CBO can contact the individual to facilitate access to medications. Jail B suffers a 3-4 week lag in the provision of HIV medications to individuals that are incarcerated and sometimes inmates are discharged without access to medications.

7.4.5 CONTINUATION OF CARE/LINKAGE TO COMMUNITY BASED ORGANIZATIONS/AIDS SERVICE ORGANIZATIONS UPON RELEASE

Some of the county jails partner with a CBO or LHD in which they establish care while individuals are still incarcerated and to facilitate the continuation of care upon release. They may come into the jail once a week to work with HIV positive individuals. Specifically the health department acts as a liaison between community-based organizations and those who are incarcerated in Jail A and B. In Jail B, a service agency can contact the individual after they are released to conduct case management and provide information on social services, However if there is no release date on a client, the health department is unable to link them to the service agency. Ideally this communication has been facilitated between the individual and service agency by the health department for a smooth transition.

7.4.6 BARRIERS TO CARE

Each county experiences unique barriers to care that need to be recognized for future programming. The two largest issues within the jails are their relationship with the LHD and stigma or confidentiality issues among the correctional staff and the detainees. Inmates are not comfortable receiving services due to not feeling that their status is confidential. In many of the county jails interviewed, there is a lack of trust and communication between the jail and LHD staff, such as, the LHD is only contacted when the jail identifies an individual as being HIV positive and is not notified of their release. This disconnect makes it difficult to coordinate services. Furthermore the LHD may not be allowed to enter the jail or do HIV testing if allowed access, due to issues with clinic space, procedures and medical supplies. Other issues include gaps in care due to the referral process. Lastly, LHD staff reported that care is reactive rather than proactive and that care is not a priority unless there are active symptoms.

7.4.7 RECOMMENDATIONS

The following suggested recommendations were provided during the interviews to increase the access to, effectiveness and efficiency of services provided to individuals with HIV throughout Detroit Metro Area while incarcerated and upon release. Nurses should to give an educational presentation on the benefits of HIV testing and the availability of linkage services at intake or at additional medical encounters. MDHHS could provide trainings to nurses and correction staff on HIV prevention and care education to aid in reducing stigma and confidentiality issues. The establishment of HIV testing as part of routine process for the identification newly diagnosed individuals upon entry. Individuals with HIV should be engaged in the jail setting, linked to community care and retained in HIV care for at least 6 months post- release. Medical and psychosocial services need to work together in order to link and retain individuals to care. Psychosocial services can work with the LHD if follow-up care is needed. All jails should work directly with a case management program. Medication, counseling, health education and housing assistance services should be provided by case managers and provide key linkage and engagement services.

Table 155: Comparison of DMA jail services for individuals with HIV in the jail system, DMA, 2015

Jail A	Jail B
HIV Testing	
<ul style="list-style-type: none"> • All at risk individuals and those who have never been are tested • Jail Staff 	<ul style="list-style-type: none"> • No information on who is tested or their process • Jail Staff conducts HIV testing
Process of working with HIV positive individuals:	
<ul style="list-style-type: none"> • CBO comes in once a week to provide Case Management • Full time staff from the university and the area medical center when specialist is required 	<ul style="list-style-type: none"> • Medical regiments are continued by non-ID physician • An ID doctor is only called when a CD4 count is below a certain level
Process of working with newly diagnosed individuals:	
<ul style="list-style-type: none"> • CBO comes in once a week to provide case management 	<ul style="list-style-type: none"> • The Jail will call the LHD but this is extremely infrequent
Medication	
<ul style="list-style-type: none"> • They are provided medication throughout the incarceration period and a 2 week supply upon release 	<ul style="list-style-type: none"> • There is a 3-4 week lag in the provision of HIV medications • Some inmates are discharged without access
Release	
<ul style="list-style-type: none"> • Continue with the Case Manager from the CBO 	<ul style="list-style-type: none"> • A local Service Agency will contact after release
Barriers	
<ul style="list-style-type: none"> • Funding • Confidentiality issues • Stigma 	<ul style="list-style-type: none"> • Lack of communication and trust between LHD and the jail • Confidentiality

SECTION 8. SOCIO-POLITICAL FACTORS IMPACTING THE HIV/AIDS EPIDEMIC IN MICHIGAN

Individuals in Michigan face a variety of systemic issues impacting their ability to access care for HIV-related health needs. Recognizing these many barriers, members of the Steering Committee participated in a brainstorming session to discuss some of the socio-political factors impacting the HIV/AIDS epidemic in the state. Eighteen Steering Committee members were present at this brainstorming session, representing the following organizations: the Michigan Department of Health and Human Services (MDHHS); the Southeastern Michigan HIV/AIDS Council (SEMHAC); the Michigan HIV/AIDS Council (MHAC); the Detroit Department of Health and Wellness Promotion (DDHWP); the HIV/AIDS Resource Council (HARC); the Grand Rapids Red Project; the Wayne State University (WSU) Midwest AIDS Training and Education Center (MATEC); and AIDS Partnership Michigan (APM). Information gained from this session can be used, in combination with the other needs assessment data, to establish effective and sustainable systems change initiatives.

The brainstorming session utilized the Mobilizing for Action through Planning and Partnerships (MAPP)'s Forces of Change Assessment process and discussed challenges, opportunities and next steps pertaining to the below questions:

- What has been/is the impact of the Affordable Care Act (ACA) on the demand or need for Ryan White services?
- What can be better done to foster the integration of prevention and care services at both the state and local levels?
- What do you believe are the most common barriers to prevention and care services among persons living with HIV/AIDS in Michigan (e.g. poverty, cultural barriers, stigma, transportation, homelessness/housing instability, inability to navigate the system, comorbid conditions, etc.)?

The challenges that were discussed, along with their associated opportunities and next steps, were then organized by theme. An opportunity or next step was not always given for each challenge, though a majority of the opportunities and next steps relate to multiple challenges.

While questions and issues addressed and discussed in this brainstorming session are all important, there are many other systemic issues impacting individuals with HIV/AIDS on a daily basis that were not thoroughly addressed during this session. These may include social and structural barriers (stigma, gender equality, etc.), state or local legislative policy barriers (routine testing, insurance, etc.), program related barriers (data on effective programming, etc.), provider-related barriers (provider stigma, lack of access, etc.) and socioeconomic or structural barriers (lack of transportation, no childcare, etc.).

A. Increased Demand

1. Financial Assistance

- There has been an increase in demand for financial assistance among persons living with HIV/AIDS with insurance through the ACA/Medicaid Expansion exchanges. This increase in demand is due to the reality that medical expenses such as lab work, medications and dental coverage are still too expensive or not covered by the ACA/Medicaid Expansion.

2. Transportation Services

- Even though non-emergency transportation should be covered by the Healthy Michigan Plan, there have been a variety of difficulties in actually obtaining transportation for clients.
- Lack of transportation is a barrier to being able to access, obtain and continue services.

3. Housing Services

- There is a lack of housing and other housing issues for many persons living with HIV/AIDS. Unstable housing compounds the additional issues individuals experience in seeking and staying in care.

B. Increased Need

1. HIV Specialists

- There is a great need for HIV specialists in a variety of settings. ASOs and other care/prevention organizations serving persons living with HIV/AIDS and those at-risk need more individuals with specialized education and training.
- Many HIV specialist providers already have large caseloads and many are nearing retirement age. This may exacerbate the issue of there already being a shortage of specialist providers.

2. Specialized Education and Training

- AIDS serving organizations and other care/prevention organizations serving persons living with and at-risk for HIV/AIDS need more individuals with specialized education and training.
- Many providers lack education, training or cultural competency to work with persons living HIV/AIDS.
 - Increasing education and training for medical providers can help to decrease provider stigma attached to the treatment of persons living with HIV/AIDS and increase knowledge for these providers. This strategy can also help to increase the number of providers that specialize in HIV/AIDS care.
- Currently primary care providers do not provide PrEP and PEP services and are not educated on providing these services.
 - An expansion of medical/HIV centers willing to prescribe and administer PrEP and PEP would help to alleviate some of the burden on infectious disease specialist clinics.

3. Mental Health Care Services

- Many clients need and/or receive mental health services, but these services are usually not provided by individuals with specialized HIV/AIDS knowledge.
 - Persons living with HIV/AIDS and those at-risk need specialized mental health care rather than standard mental health services

- Mental health services for persons living with HIV/AIDs are inadequate.

C. Increased Caseloads

- Case managers and HIV/AIDS service organizations indicate that confusion over coverage as a result of the ACA/Medicaid expansion has been difficult and that this is causing workers to spend more time assisting clients with coverage issues. This has impacted the ability to maintain caseloads and provide other vital services to those living with HIV/AIDS.
- Despite the implementation of the ACA/Medicaid expansion, there has been an increased demand for case worker services and those burdens have yet been alleviated. Due to difficulties experienced by clients in accessing services that should be provided through their insurance as a result of the ACA/Medicaid expansion (e.g., transportation services), there has been an increased amount of time being spent by ASO workers in filing claims with/against insurance companies.

D. Issues with Medication Coverage

- There is currently a lack of coverage around PrEP and nPEP and Ryan White coverage needs to expand coverage to include those with short-term, high-risk exposures. Exposed or infected infants also lack access to medications due to difficulties in reimbursements and hospitals not carrying starter packs of medications.
 - Increase guidance on PrEP and nPEP to providers and organizations.
 - Expansion of medical/HIV centers willing to prescribe and administer PrEP and PEP. This expansion will help to alleviate the ID clinics and other organizations that are currently providing these services.
- HIV medications are a high-tier level of medication. These medications are not on-par and as accessible as medications available for many other chronic, manageable conditions.

E. Issues with Insurance Coverage

- A number of Ryan White clinics provided services are not covered under the Healthy Michigan Plan (HMP). These include early intervention services, health insurance premium and cost-sharing assistance, nutrition therapy, some other support services and medical case management. There have also been discrepancies on how this and preventive care are defined among insurance providers. More data is needed to support that Ryan White cost-sharing funding is vital.
 - Pulling and analyzing AIDS Drug Assistance Program data and other pertinent data is an important step in supporting HIV/AIDs funding. This data would be the justification for continued and expanded funding for HIV/AIDs programming, staffing, etc.

F. Issues with Service Provision

- Service delivery is often segmented with long wait times for appointments and long wait times to be seen by a medical provider.

- Prioritizing the provision of some services will alleviate segmented service delivery. This will decrease wait times for appointment and wait times for medical care.
- There is a concern over the privacy of services.
- The uninformed usage of the terms “chronic” and “manageable” in the provision of care to those with HIV/AIDs is an issue.
- There are a number of individuals that become lost to the care system. This issue is particularly high in youths, incarcerated individuals and homeless/transient individuals. It is important that all individuals living with HIV/AIDs stay active within the care system in order to obtain the care and medications that they need.

G. Stigma

- Stigma is still an issue impacting the HIV/AIDs community, both among the general population as well as among those providing services and treatment to persons living with HIV/AIDS. Among those individuals who identify as LGBTQ or who are substance users, stigma is an even bigger concern.
 - Increase advocacy for persons living with HIV/AIDS and those at-risk, particularly at the state level.
 - Create an anti-stigma media campaign that focuses on a positive and normalizing message aimed at the general public. This will help to educate the public on persons living with HIV/AIDs and decrease the stigma attached to this population.
 - Work to build a more cohesive HIV community by fostering communication and collaboration that will then be able to build an ad advocacy group to represent the voice and needs of the HIV community to the state and legislature. This group can work to propose and support policy changes, such as modifying the HIV disclosure law.
 - Increasing education and training for medical providers will help to decrease provider stigma attached to the treatment of persons living with HIV/AIDs and increase knowledge for these providers. This strategy will also help to increase the number of providers that specialize in HIV/AIDS care
- The HIV disclosure law is a barrier in that if you have HIV you must disclose your status to any partners and the ability of partners to then disclose your status without your permission. There are also difficulties involved in the legal process in charging someone who has disclosed your HIV status without your consent.
 - Increasing the support for abolishing/changing the Michigan disclosure law at the legislative level. Increasing advocacy efforts will help to educate legislators and identify individuals to lead this effort.
- Substance abuse and the fear of substance abusers in seeking treatment due to being stigmatized or judged is a major barrier for persons living with HIV/AIDS in Michigan. To avoid judgment, many substance users are not receiving appropriate HIV/AIDs services or care, which puts their health at higher risk for complications.

- The creation of a media drug campaign targeting meth and other drugs of concern for persons living with HIV/AIDs will help to educate and prevent substance abuse, which will then help to prevent persons living with HIV/AIDS from not seeking care services.

H. Organizational Issues (Local, State and National)

1. Local and State

- Michigan public health and health services are fractured. There remains a lack of cohesion and/or integration that is vital to addressing issues and creating sustainable changes.
- There is a lack of integration between the state and local organizations at many levels. This includes differences in important timelines, funding structures, etc.
 - Increase coordination, collaboration and communication among stakeholders and the HIV community at all levels. This will help to establish a more cohesive and integrated HIV community focused on working together on shared goals and advocating for the needs of the HIV community. This group can lobby for change at the state level and work to address the HIV disclosure law and drug formulary restrictions.
 - Having state level and local organizations work together to identify outcomes and plan together on how to achieve these outcomes can foster a more cohesive and integrated network. Collaborating with stakeholders and involving the community at large will also help to integrate the collective HIV/AIDS voice throughout Michigan. State level consultations would also be beneficial to achieving integrated services. It is important to recognize that all persons living with HIV/AIDS will benefit from more effective services and enhanced advocacy supported through a more integrated system.
- The fear of losing clients has created an environment of competition. When organizations lose clients, they can possibly lose funding and this has created turf wars among HIV/AIDs organizations. There is also a lack of sharing and coordination of resources such as staff and trainings.
 - Working together to identify and establish roles and responsibilities for organizations will help to avoid turf wars and environments of competition.
- There is a strong need for greater technical assistance and quality assurance from the state level to local organizations providing HIV interventions. This would include providing education/training in service provision of counseling, testing and referral (CTR) and other current HIV interventions services. There is a high level of fatigue among organizations and individuals who work within the HIV/AIDs community.
 - Increasing the capacity at the state level to provide local organizations with specialized training and technical assistance with currently funded HIV interventions while working with national providers. This can be achieved by

establishing, maintaining and committing to staffing models at the state level that will encourage technical assistance and quality assurance support.

- There are issues with HIV/AIDS related terminology. There is a disconnect between those within the community and government/funders in terms of the use of the phrase “Stage 3 (AIDS)” versus “AIDS”. AIDS is preferred at the community level, whereas government/funders over-utilize “Stage 3 (AIDS)”.

2. National

- The expectations of national organizations have created barriers to integrating services.
- There are tight regulations with regards to funding only being able to be spent for certain activities. This limits the expansion of activities or the ability of organizations to be flexible based upon the evolving needs of the programming within the organization.
 - Focusing on funding is an important step in addressing integration. Reconstructing funding distribution throughout the HIV/AIDS community would be one strategy to address integration. Recent funding sources such as the new Coordinated Care Networks can also potentially help to overcome integration challenges. Recognizing that one model does not fit all and establishing a model where programs are funded based on whether or not they are able to achieve outcomes would be an idea. This will hold programs more accountable and prevent the funding of a program that may have worked in one community but may not work in a different community. Having Requests for Proposals be more coordinated between care and prevention is also a funding strategy that would help to address integration.
- There is a discrepancy between the Centers for Disease Control’s (CDC) targeted testing population and other funders’ testing population.
 - Continuing discussions on how the CDC’s policies clash with performance indicators. These discussions need to focus consistently on the issues that these testing policies are creating.

General Opportunities:

- While funding is an important resource, it is also important to focus on leveraging a variety of resources that will support prevention and care services.
- Prevention with Positives programming has helped to bring prevention service models into traditional care-focused sites, which is increasing their capacity to do prevention and care. EIS also provides the same potential to integrate services.
- Expanding data collection, revising current data collection systems and utilizing data to understand various trends throughout the HIV/AIDS community will allow for expanded knowledge in areas such as service utilization for persons living with HIV/AIDS, service utilization for individuals at-risk, barriers to treatment, etc.
- Utilizing the Early Identification of Individuals with HIV/AIDS workgroup that is focused on linking prevention, care, and surveillance throughout Detroit.

SECTION 9: PRELIMINARY NEEDS ASSESSMENT RECOMMENDATIONS

Several preliminary recommendations can be made based on the results of this needs assessment. Recommendations are grouped in categories with the understanding that several recommendations can fit in more than one category. The recommendations contained in this report do not constitute final recommendations. Final recommendations based on this needs assessment will be made by the various planning bodies during the planning process.

Testing sites and Primary Care Providers

- Providers not offering HIV tests were one of the main reasons that at-risk persons did not get tested. Providers should offer an HIV test to anyone at risk for HIV.
- Case managers should be on site and available at the time of a positive test so that newly diagnosed can immediately be linked to someone who can provide them with guidance.
- Although most are linked to care within 3 months, those who aren't quickly linked to care tended to be out of care later. Testing sites should take responsibility for the early linkage of newly diagnosed individuals to care to minimize the risk of future periods of being out of care.
- Offer PrEP to or refer individuals who may be good candidates.
- Early testing will decrease late stage diagnosis increases and increase quality of life and reduce transmission rates

Jails/Prisons

- Jails and prisons should offer HIV testing as part of routine care upon entry into the system.
- All jails and prisons should work directly with a HIV case management program.

Prevention (for negatives and positives) Providers

- Target prevention efforts to the populations most affected by new diagnoses, namely young (20-29 years of age), and black men who have sex with men
- Offer educational materials and other skill building sessions on how to prevent HIV, including risk reduction behaviors and prevention medication (e.g., PrEP).
- The majority of persons surveyed living with HIV would like to participate in a group or individual prevention program. Continue to offer group and individual programming and ensure that qualified facilitators/teachers are available to meet the client demand/interest.
- Additional programs for persons living with HIV should include components that address stress reduction, feeling better about their HIV status, and disclosure of their HIV status to family members and friends.

Service providers

- Ensure that persons living with HIV have access to mental health counseling, stress reduction counseling, and social support groups that provide contact with people that they can relate to
- Mental health assistance via individual and group sessions should especially be provided to the newly diagnosed to better help them deal with their HIV status

- Basic needs like housing and food were not always met among many persons living with HIV. Work with homeless shelters, organizations that provide housing assistance, and food pantries to ensure that these basic needs of persons living with HIV are met.

Care providers

- Maintain constant communication with testing locations to ensure that persons who are newly diagnosed are quickly linked to care.
- Workload increases due to Medicaid Expansion were a problem for many providers. Health care systems should reevaluate the efficiency of their operations to ensure that they will be able to meet the needs of their increased client load.
- Health care systems in areas of high unmet need should reevaluate their systems for outreach to ensure that everyone who needs care can receive it.
- Reach out to individuals who miss appointments to ensure that they don't fall out of care.
- Provide transportation and transportation assistance to ensure that persons living with HIV are able to make it to their appointments.
- Unstable housing was a reason for being out of care. Providers should screen for housing stability among clients to anticipate future needs that may affect retention in care.
- Have frank conversations with patients/clients about the importance of remaining in care even if the person feels healthy.
- Ensure dedicated staff members to assist patients with insurance coverage.
- Dental care was the medical service most mentioned by persons living with HIV. Screen patients for dental needs and refer to local dental providers.
- Hepatitis C treatment?

Training

- Providers need training on cultural sensitivity
- Ensure that providers understand the hectic and stressful lives that persons living with HIV lead so that they can provide care and services that are more appropriate for their lifestyles.
- Changing rules and policies with the implementation of Medicaid expansion led to additional provider confusion. More provider training is needed on the nuances of the new plans and how to appropriately bill for services.
- Ensure that dental providers feel comfortable offering dental services to persons living with HIV.
- Offer HIV training to general medical providers to increase their comfort with providing care and services to persons living with HIV; specifically the different subgroups that are more common in this population (e.g., LGBTQ, transgender, etc.)
- Many surveyed providers have practiced in the field for more than 11 years and may reach retirement age soon. Work with medical and nursing schools to increase the number of providers that choose HIV as a specialty to address capacity issues
- Ensure providers are aware of programs and tools to address opioid overdose.
- Ensure that providers are comfortable treating co-infection with Hepatitis.

Funding organizations

- Provide additional financial assistance to health care and service providers to ensure that they have enough staff to meet the increased demand for their services.
- Ensure that HIV tests for any person who may be at risk are covered/reimbursable.
- Ensure that prevention medication such as PrEP is covered by insurance/reimbursable.
- Although the DMA makes up 43% of the population, they make up 65% of the HIV population in the state. Ensure the equitable distribution of resources to ensure that this high burden area has the care and prevention services it needs.
- Several geographic locations have high unmet need (defined by viral suppression). Target funding for care and case management to those areas—specifically Berrien and Genesee counties with the highest prevalence of unmet need.
- Funding should also be targeted to better integrate prevention and care activities
- Viral suppression is lowest among young people living with HIV and minorities. Provide funding for research to determine if low viral suppression rates are due to medical noncompliance or a different effect of ART medication on these populations.
- Case managers were listed as an important resource for persons living with HIV. Ensure there is enough funding for each person living with HIV who needs a case manager to have one.

SECTION 10: MICHIGAN'S PREVENTION, CARE AND SUPPORT SERVICES: RESOURCE INVENTORY

Michigan's Prevention, Care, and Support Services: Resource Inventory

Per guidance from CDC and HRSA, a statewide HIV/AIDS resource inventory was developed as part of the 2015 needs assessment process. While previous resource inventories were available, none were comprehensive across the state. The purpose of this resource inventory is to provide up-to-date information on organizations throughout Michigan providing prevention, care and support services for individuals living with HIV/AIDS and at-risk for HIV. It is also intended that this inventory be used by HIV medical professionals and service providers to provide additional resources and referrals to their patients and clients. Though recommended by HRSA, this resource inventory does not provide information on number of clients served at each organization, nor does it provide information on funding levels and sources. This resource inventory was developed solely as a user-friendly guide that will be accessible via the MDHHS website for the general public and that can easily be maintained and updated by MDHHS staff each year. The resource inventory is a separate document that can be found in the Appendix, along with a user-friendly glossary describing each service that will also be made available to the public with the inventory.

Inspired by services funded by HRSA's Ryan White HIV/AIDS Program in addition to integral services identified by members of the HIV Project Planning Steering Committee, the services listed in the resource inventory include:

1. HIV Prevention Services

- HIV Testing
- STI Screening
- Partner Services
- PrEP/nPEP Services
- Peer Support
- Syringe Service Programs
- Substitution Therapy (e.g., Methadone)
- Individual Counseling
- Group Intervention

2. HIV Care Services

- Linkage to Care (e.g., referrals)
- HIV Medical Care
- Prevention Services (e.g., evidence-based prevention for positives programs)
- Insurance Navigation
- Home Health Services
- Hospice Care
- Mental Health Services
- Substance Abuse Outpatient Care
- Medical Case Management
- Dental Services

3. HIV Support Services

- Non-medical case management
- Emergency Financial Assistance
- Food Assistance
- Health Education
- Housing Assistance
- Legal Assistance
- Medical Transportation Services
- Support Groups
- Rehabilitation Services (e.g., physical and occupational therapy)
- Residential Substance Abuse Services
- Treatment Adherence Counseling

Created in Microsoft Access, the resource inventory database can be maintained and updated by MDHHS staff as needed. In its end-user format, the resource inventory is presented by county in Michigan; organizations providing any of the aforementioned services are listed along with the service(s) they provide and their up-to-date contact information.

The resource inventory was developed using a combination of pre-existing resource guides and lists of funded organizations as provided by members of the Steering Committee and MDHHS. All organizations were compiled and entered into the Access Database after being researched online to confirm contact information and services provided. Occasionally, organizations and websites would snowball to others offering similar services or receiving service referrals, in which cases those organizations would then too be added to the inventory. In some instances, the organizations and services provided did not fit neatly into a pre-existing category (e.g., optical care, employment assistance and job placement, domestic and sexual violence shelters); in these cases, the services provided were listed in a “notes” box, visible to end-users, and no services were checked.

SECTION 11: DATA: SOURCES, SYSTEMS AND LIMITATIONS

11.1 DATA SOURCES

This needs assessment involved both primary data collection and secondary data collection. In February 2014, the HIV Planning Steering Committee convened to review a presentation of secondary data and, drawing on the available materials as well as their own knowledge and expertise, identified key findings and information gaps. Committee members then used these findings and information gaps to develop survey goals for primary data collection among people living with HIV (PLWH), persons at-risk for HIV infection, and professionals who provide care and support services to PLWH. This process helped to lay the groundwork for the needs assessment report. Secondary data collection was drawn from information in a range of reports from both publicly available data sources and data made available from members of the HIV Planning Steering Committee, including surveillance data, national and state-level surveys, results from community engagement and sexual health surveys, findings from an evaluation of the provision of HIV care and services in jails, as well as client-level data from the Ryan White Part A HIV/AIDS Program and Counseling, Testing, and Referral data from the MDHHS HIV Event System. These data and reports provide insight into the experiences and needs of PLWH in Michigan and the Detroit Metropolitan Area (DMA). Data collection tools and the final data presentation are located in the Appendix. Sources for the secondary data collected are briefly described below.

Surveillance Data

Birth and Death Data: The National Center for Health Statistics receives information on births and deaths in the United States through a program of voluntary cooperation with state government agencies (i.e., state departments of health, state offices of vital statistics) called the Vital Statistics Cooperative Program. States use standard forms to collect birth and death data. The birth certificate form includes demographic information on the newborn and the parents, insurance status, prenatal care, prenatal risk factors, maternal morbidity, mode of delivery, pregnancy history, and clinical characteristics of the newborn. Death certificates include demographics, underlying causes of death, and contributions of selected factors to the death of all deceased persons. Reporting is virtually 100 percent complete for births and deaths. Therefore, inferences can be made concerning the number of live births in a service area. The data can also be used to determine the effect of deaths related to HIV infection in a service area. Birth certificate data are obtained from patient medical records (i.e., smoking history, morbidity), which may be incomplete. In addition, deaths resulting from HIV, or whose underlying cause was HIV infection, may be underreported on death certificates. Clinical information related to HIV infection may be missing. Website: http://www.michigan.gov/MDHHS/0,4612,7-132-2944_4669---,00.html

HIV/AIDS: The enhanced HIV/AIDS Reporting System (eHARS) is the surveillance database that contains information on all reported cases of HIV in Michigan, which includes all stages of HIV, including Stage 3 (AIDS) (AIDS). In addition Michigan's Laboratory Management System (LMS) is imported into eHARS, making HIV diagnostic tests, CD4+ T-lymphocyte (CD4) counts, and HIV viral load data available for analysis. The HIV Case Reporting and Data team is part of the HIV/STI, Body Art, Tuberculosis, and Viral Hepatitis Section in the Division of Communicable Diseases, which is part of the MDHHS Bureau of Disease Control, Prevention, and Epidemiology. The HIV Case Reporting and Data team, collects, analyzes, interprets, and reports on the spread of HIV in Michigan and produces an array of Michigan-

based HIV surveillance reports, HIV incidence reports, HIV trends analyses, analysis of unmet need, reports on the National HIV/AIDS Strategy Implementation, HIV care continuum, and epidemiological profiles for the entire state, and in some cases Southeast Michigan and the City of Detroit. Although eHARS is extensive, it is based on data for persons who have been confidentially reported. Therefore, anonymous cases and undiagnosed cases are not included and HIV infections are under-detected and underreported. eHARS data do not provide a true measure of HIV incidence. Persons are tested at differing times after they become infected, and many persons are not tested until HIV infection has progressed to Stage 3 (AIDS) (late diagnoses). Website: www.michigan.gov/MDHHS/0,4612,7-132-2940_2955_2982_72251-349641--,00.html

Population Data: The Census Bureau collects and provides timely information about the people and economy of the United States every 10 years and releases annual population estimates between those years. The Census Bureau's website includes data on demographic characteristics of the population, family structure, educational attainment, income level/employment status, housing status, and the proportion of persons who live at or below the Federal Poverty Level (FPL). Summaries of the most requested information for states and counties are provided, as well as analytical reports on population changes, age, race, family structure, and apportionment. State- and county-specific data are accessible, and links to other web sites with census information are included. Website: factfinder.census.gov

STIs: In accordance with the Public Health Code, cases of Sexually Transmitted Infections (STIs), including gonorrhea, syphilis, chlamydia, and hepatitis B are reported by laboratories and clinicians to local health departments. Action is taken to ensure appropriate care and provide rapid follow-up for priority cases. These reports are then forwarded to the Michigan Department of Health and Human Services via the Michigan Disease Surveillance System. Because the information is obtained from health care facilities providing testing to individuals with sexually transmitted infections, it is likely that the number of cases reported under represents the incidence of sexually transmitted infections in the population. For chlamydia and gonorrhea, this under representation may be substantial. Reporting relies heavily on laboratory reporting data and analysis may be limited due to missing demographics. Website: www.michigan.gov/MDHHS/0,1607,7-132-2940_2955_2982_46012---,00.html

Behavioral Surveys:

MiBRFS: The Michigan Behavioral Risk Factor Survey (BRFS) is an annual, state-level telephone survey of Michigan residents, age 18 to 64 years. These annual, state-level surveys, act as the only source of state-specific, population-based estimates of the prevalence of various behaviors, medical conditions, and preventive health care practices among Michigan adults. Michigan BRFS results are used by public health agencies, academic institutions, non-profit organizations, and others to develop and evaluate programs that promote the health of Michigan citizens. The annual Michigan surveys follow the CDC survey protocol for the BRFSS. In 2011, both landline and cell phones were included in the sampling protocol. Cell phone numbers are randomly selected from dedicated cell phone banks that are sorted based on area code and exchange within each state. In addition to the annual standardized core questionnaire, the Michigan BRFS includes about 25 state-added questions each year. To minimize the

impact of the lower telephone coverage for population subgroups such as people with low incomes, people in rural areas, people with less than 12 years of education, people in poor health, and heads of households under 25 years of age, iterative proportional fitting (IPF), also known as raking, is applied to make adjustments for age, race, sex, and various other demographic variables. Surveys based on self-reported information may be less accurate than those based on physical measurement as there may be instances of under-reporting or over-reporting and should be taken into consideration when interpreting the data. Website: www.michigan.gov/MDHHS/0,1607,7-132-2945_5104_5279_39424---,00.html

SAMHSA: The National Survey on Drug Use and Health (NSDUH) provide National and state-level data on the use of tobacco, alcohol, illicit drug use (including non-medical use of prescription drugs), and mental health in the United States. NSDUH is sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA) an agency of the US Public Health Service in the US Department of Health and Human Services (DHHS). The NSDUH is an annual survey involving a scientific random sample of households across the United States and a professional interviewer makes a personal visit to each selected household. Participants complete the interview using a laptop computer and enter their responses directly in the computer. For some items, the interviewer reads the question aloud and enters the participant's response. Civilian, non-institutionalized individuals aged 12 years and older are eligible to participate. For this reason, the NSDUH does not capture or under reports on the homeless population and institutionalized individuals.

YRBS: The Youth Risk Behavior Survey (YRBS) is conducted every other year in Michigan by the Department of Education and assesses a broad range of health practices among a representative sample of the state's students in grades nine through twelve. Data are weighted so that survey results can be generalized to all high school students in the state. The YRBS collects information on six categories of behaviors related to the leading causes of mortality and morbidity among both youth and adults. Sexual behaviors that contribute to unintended pregnancies and STIs, including HIV infection, constitute one of the six categories. Questions in this category ask about HIV prevention education, sexual activity (age at initiation, number of partners, condom use, past drug or alcohol use, forced sex, sex of sexual partner), and contraceptive use. The YRBS is a standardized questionnaire, so comparisons can be made between states, participating cities, and the nation on core questions. Because the YRBS relies upon self-reported information, sensitive behavioral information may be under-reported or over-reported. Also, because the YRBS questionnaire is administered in schools, the data are representative only of adolescents who are enrolled in school and cannot be generalized to all adolescents. Website: www.michigan.gov/yrbs

Client-Level Data:

MDHHS CTR Data: The Michigan Department of Health and Human Services (MDHHS) HIV Care and Prevention Section has designated HIV Counseling and Testing Sites throughout Michigan. Agencies designated as an MDHHS HIV Test Site must provide HIV testing to one or more of the priority populations identified in Michigan's Jurisdiction Plan, such that a majority (>50%) of clients represents one or more of these priority populations, be expected to enhance linkage to HIV medical care for people who are HIV positive, and promote condom use distribution to people living with HIV and high

risk individuals in the State of Michigan. The HIV Care and Prevention Sections works in collaboration with various partner agencies including rural and urban public health representatives, AIDS service organizations, non-governmental organizations, and community-based organizations. Counseling, Testing, and Referral (CTR) data collected from Designated MDHHS HIV Test Sites is housed in the HIV Event System, which stores information of persons who have tested for HIV and includes demographic characteristics as well as risk behaviors.

Ryan White HIV/AIDS Program: All Ryan White contractors (i.e., HIV service providers) are required to report on some clinical outcomes, as well as service delivery/utilization and client descriptive data. CAREWare is the software program developed by the Health Resources and Services Administration (HRSA) to collect and report the Uniform Reporting System (URS) data. The URS, which was implemented in Michigan in 1994, is a statewide client-level data standard designed to consistently document the quantity and types of services provided by agencies receiving Ryan White funds. There are currently four separate CAREWare databases. The City of Detroit Department of Health and Wellness Promotion (DHWP) is the Part A Grantee designee and maintains the CAREWare database for Part A-funded programs.

Primary data collected during the Needs Assessment Process

Survey among persons living with HIV/AIDS in Michigan. As the first phase of the Themes and Strengths portion of the MAPP assessment (see Section 1.1 Needs Assessment Process), a statewide, in-person survey was administered among persons living with HIV/AIDS. The purpose of this survey was to supplement and address gaps in existing secondary data within the state. An original survey, consisting of both multiple choice and open-ended questions, was developed by MPHI with feedback from members of the Themes and Strengths and Steering Committees. Survey topics included HIV testing and diagnosis, partner services, initial linkage to medical care and care services, initial linkage to a case manager and support services, current use of medical care and support services, HIV medications, viral suppression, services needed, PrEP knowledge and attitudes, and suggestions for service improvement. However, because survey data were not a random sampling of the population, data does not represent the population as a whole and cannot be generalizable. Participants were recruited from local health departments, HIV/AIDS service organizations (ASOs), community based organizations (CBOs), HIV/AIDS support groups, testing facilities, Ryan White providers, bars and social settings as referred by members of the Steering and Subcommittee members. Organizations were asked to target recruitment efforts to persons living with HIV from specific groups (e.g., young black men who have sex with men, transgender individuals, injecting drug users, individuals who were recently out of care, etc.). Several organizations and support groups were chosen as recruitment locations because of their primary client population represented one of our targeted groups. Surveys were administered during July and August in 2015 in a private location by trained interviewers or self-administered if a participant preferred to do so. The consent process and survey administration took anywhere from 45 minutes to 1 hour and respondents were provided a \$20 Visa gift card for their time.

Survey among persons at risk for HIV/AIDS in Michigan. As part of the Themes and Strengths portion of the MAPP assessment (see Section 1.1 Needs Assessment Process), a statewide, in-person survey was

conducted among persons at risk for HIV/AIDS. The purpose of this primary data collection was to supplement and address gaps in existing secondary data within the state. An original survey, consisting primarily of multiple choice questions, was developed by MPHI with feedback and input from the Themes and Strengths and Steering Committees. Survey topics included history of HIV testing, participation in risky behaviors, HIV/STI prevention education, partner services, prevention of HIV, and knowledge and attitudes regarding pre-exposure prophylaxis (PrEP). However, because survey data were not a random sampling of the population, data does not represent the population as a whole and cannot be generalizable. Participants were recruited with the assistance of local health departments, HIV/AIDS service organizations (ASOs), community based organizations (CBOs), HIV/AIDS prevention support groups, testing facilities, and social settings as referred by members of the Steering Committee and Subcommittees. Organizations were asked to target recruitment efforts to persons at risk for HIV from specific groups (e.g., young black men who have sex with men, transgender individuals, injecting drug users, high risk heterosexuals, etc.). Several organizations and support groups were chosen as recruitment locations because their primary client population represented one of our target groups. Surveys were administered in a private location by trained interviewers or self-administered if a participant preferred to do so. The consent process and administration of the survey took anywhere from 30 to 40 minutes to complete and respondents were provided a \$20 Visa gift card for their time.

Survey among Professionals Providing Care and Services to Persons Living with HIV/AIDS: As part of the health systems assessment (see Section 1.1 Needs Assessment Process), we surveyed professionals throughout Michigan who provide care or services to persons living with HIV to gain a better understanding of how medical and service providers counsel or treat patients and of the barriers experienced while providing care or services to persons living with HIV/AIDS. Of particular interest to the HIV Planning Steering Committee was how the Affordable Care Act and Medicaid expansion impacted care and service delivery for persons living with HIV/AIDS in Michigan. The survey was self-administered and respondents had the option to respond to an online version via Survey Monkey or a hard copy that was mailed to the provider office. The survey consisted of mostly multiple choice questions and took approximately 30 minutes to complete. Providers were not given an incentive for their time. Survey questions were reviewed by the Steering and Subcommittee for readability, consistency with survey goals, and for content. Survey topics included: provider demographics, providers comfort discussing HIV transmission and care, services routinely offered to patients or clients with HIV, how providers link persons living with HIV/AIDS to medical and support services, provider confidence in medical, dental, and support services offered to persons living with HIV/AIDS, antiretroviral medications that prevent HIV transmission, barriers to providing care or services, patient experiences, and current education needs. However, because survey data were not a random sampling of the population, data does not represent the population as a whole and cannot be generalizable.

Community Engagement and Sexual Health Survey: In 2015, seven community engagement and sexual health surveys were carried out by a representative in the HIV community among various populations in the Detroit Metropolitan Area and surrounding counties. Questions focused on the respondents' own personal concern for HIV infection, frequency in which HIV/STIs were discussed with family, friends, and medical professionals, whether the respondent had ever been tested for HIV, whether information on

safer sex had ever been received, and of knowledge about Pre-exposure prophylaxis (PrEP). Information collected from these surveys provides insight concerning issues related to HIV prevention and offers understandings into the opinions of the community. However, because survey data were not a random sampling of the population, data does not represent the population as a whole and cannot be generalizable.

Michigan Jail HIV Evaluation: A statewide survey of Michigan was conducted with county health departments to obtain information on how jails throughout Michigan handled identifying and providing care to incarcerated persons living with HIV. This survey was accomplished by contacting health department staff in five high incidence counties (Genesee, Kent, Washtenaw, Wayne and Oakland) and a small number of community-based organizations (CBOs) that work with the local health departments. Data that were collected was provided to establish a picture of the current state of Michigan jails' processes in working with persons living with HIV. As such, this is not a complete representation of all Michigan jails and cannot be generalized to all jails and other correctional facilities.

11.2 LIMITATIONS AND CONSIDERATIONS

This needs assessment had an extremely broad focus and was commissioned with limited resources and limited time. Despite these challenges the team succeeded in gathering a wealth of information on the needs and service gaps in the Michigan HIV/AIDS community. Three key limitations/considerations that should be considered when reviewing this report are included below. This is not an exhaustive list but represents several of the largest potential limitations to the results.

1. Primary data from the needs assessment report do not represent a generalizable population of persons living in Michigan or the DMA and should not be interpreted as such.
2. The proportion of primary data collection respondents who represented some of our key target populations was lower than anticipated. Examples of key target areas are recently out of care and transgender persons living with HIV/AIDS. The interview staff worked closely with health departments and support groups to target recruitment to these hard to reach populations but unfortunately due to IRB limitations on recruitment locations, we were not able to access these in individuals in community based settings that they likely would be found in.
3. Much of the needs assessment data are qualitative which provide rich reasons for respondent behavior. Due to the short time line, these qualitative responses were not able to be recorded and transcribed. Instead interviewers relied on detailed field notes to document responses. Due to the lack of transcription availability, additional contextual information was not always available at the analysis stage.

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- Steering committee members who gave their time and insights to the needs assessment process
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- Michigan HIV/AIDS Council
- Detroit Department of Health and Wellness Promotion
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 - Affirmations
 - AIDS Partnership Michigan
 - Battle Creek VA Medical Center
 - Berrien County Health Department
 - Be Well Medical Center
 - Birmingham Royal Oak Medical Group
 - Bronson Infectious Disease and Pulmonary Medicine
 - Brothers Saving Brothers support group
 - Calhoun County Public Health Department
 - CARES (Kalamazoo and Berrien)
 - Central Michigan Department of Community Health
 - Community Health Awareness Group
 - Cherry Health
 - Children's Hospital of Michigan
 - Community Health Awareness Group
 - Corizon Correctional Healthcare
 - Detroit Community Health Connection
 - Detroit Receiving Hospital
 - Diplomat Specialty Pharmacy
 - Elsmar Home Health Care
 - Felix and Paula support group Wayne State Clinic
 - Gateway to Health
 - Genesee County Health Department
 - Gospel Against AIDS
 - HIV/AIDS Resource Center
 - HAVEN-START
 - HAVEN, Turning Point
 - Health Delivery Inc
 - Hearth Home
 - HELP
 - Henry Ford Hospital
 - Higher Ground
 - Horizons Project
 - Hurley Medical Center
 - Huron Valley Hospital
 - IHA/Infectious Disease Consultants
 - Ingham County Health Department
 - Central Michigan Department of Community Health
 - Institute for Population Health
 - Intercare
 - Kalamazoo County Health and Community Services
 - Lansing Area AIDS Network
 - UP Health Systems Medical Specialists
 - Marquette County Health Department
 - Matrix Human Services
 - McAuley Health Center
 - McClees Clinic
 - McLaren Northern Michigan
 - Menjos Bar
 - Mercy Health Mc Clees Clinic
 - Mercy Health Prevention Practices
 - Mercy Health, St. Mary's Hospital
 - Michigan AIDS Coalition
 - Michigan Department of Corrections
 - Moms in motion support group
 - Newland Medical
 - Nimkee Memorial Wellness Center
 - North Oakland Health Department
 - Northeast Guidance Center
 - Oakland County Health Division
 - Oakland County Health and Human Services
 - Oakwood

Oakwood/ Beaumont
OLHSA
OptiMed Pharmacy
Prevention for positives camp (CARES)
Public Health Muskegon County
Sacred Heart Rehabilitation Center
Saginaw County Department of Public Health
Sparrow Health System SANE Program
St. John HealthCare
St John Providence Community Health
School Based Health Centers
The Grand Rapids Red Project
Thomas Judd Clinic in Munson Medical Center (Grand Traverse)
University of Michigan
University of Michigan Health Systems
HIV/AIDS Treatment Program

Van Buren Cass District Health Department
Washtenaw County Public Health
Wayne County Juvenile Detention Facility
Wayne State Ryan White Part D Services through Children's Hospital of Michigan
Wayne State University Infectious Diseases Clinic
Wayne State University Physician's Group
Wayne State University School of Medicine
WC SAFE Program
Wellness AIDS Services
Walter P Reuther Psychiatric Hospital
WSU Adult HIV/AIDS Program
WSU- Wayne County Jail

GLOSSARY OF COMMONLY USED TERMS

- **Acquired Immune Deficiency Syndrome (AIDS):** AIDS is the final stage of HIV infection. People at this of the HIV virus have severely damaged immune systems which put them at risk for opportunistic infections. Also often referred to as stage three infection.
- **AIDS Drug Assistance Program (ADAP):** The ADAP program provides free medication for persons living with HIV.
- **Affordable Care Act (ACA):** Health care reform, ACA refers to the federal statute (HR3590) signed into law by President Barack Obama in March 2010.
- **AIDS Service Organization (ASO):** community based organizations that provide support for persons living with HIV/AIDS.
- **Antiretroviral Therapy (ART):** Medication that treats HIV.
- **At-Risk:** Refers to an individual that it is not HIV positive and may engage in behaviors that could lead to HIV transmission.
- **Barriers:** Constructs that prevent individuals from receiving HIV medical care or support services.
- **Bisexual:** Attraction to both sexes, male and female.
- **Care Continuum:** The care continuum is a five stage model that outlines the sequential stages of HIV medical care that people living with HIV go through from initial diagnosis to achieving the goal of viral suppression. The stages include: those aware and unaware of their HIV infection, HIV diagnosis; linkage to care, retention in care, and viral suppression.
- **CDC Category A Funding:** Provides funding to health departments to conduct essential HIV prevention activities. Health departments are required to direct at least 75% of funds in this category to: HIV testing; comprehensive prevention services for HIV-positive individuals and their partners; condom distribution; and efforts to align policies to optimize HIV prevention, care and treatment.
- **CDC Category B Funding:** Provides funding to states, cities, and territories with large numbers of African-Americans and Latinos living with HIV to expand HIV testing services, primarily in health care settings, for these populations and others heavily affected by HIV.
- **CDC Category C Funding:** Additional funding for health departments to implement HIV prevention demonstration projects.
- **Community-Based Organization (CBO):** Local organizations that provide prevention and support services to persons living with HIV and persons at-risk for HIV.
- **DMA/DEMA:** Refers to the Detroit metropolitan area and includes the counties of Wayne, Lapeer, Macomb, Oakland, St. Clair, and Monroe.
- **Early Intervention Services (EIS):** Funded through the U.S. Department of Health and Human Services, EIS was established to incorporate HIV prevention into medical care of persons living with HIV and to prevent new infections, increase the proportion of persons with HIV who are aware of their infection, prevent HIV related illnesses and death , and reduce HIV related health disparities (page 30 of narrative).
- **Epidemiology:** A branch of medicine that examines the incidence and distribution of diseases in humans.
- **Federally Qualified Health Centers (FQHC):** Organizations that receive grants through the Public Health Service Act. These organizations must provide comprehensive services in an underserved area.
- **Health Care and Service Providers:** Refers to the doctors and specialist that provide HIV medical and prevention care.

- **Health Care Setting:** A setting in which both medical diagnostic and treatment services are provided.
- **Health Department:** A government operated agency that serves the general public.
- **Heterosexual Contact:** Sexual contact between heterosexual partners (male and female).
- **Heterosexual:** Persons attracted to the opposite sex.
- **HIV Test:** a test that detects the presence of HIV antibodies.
- **Human Immunodeficiency Virus (HIV):** According to the Centers for Disease Control and Prevention, HIV is a virus that spread through body fluids that affects specific cells of the immune system, CD4 or T Cells. HIV can destroy so many of these cells that the body is not able to fight off infection and disease which leads to Acquired Immune Deficiency Syndrome (AIDS).
- **Injection drug use (IDU):** Intravenous drugs used by injecting a needle
- **Incentive:** a gift card provided to participants that complete the persons living with HIV survey or persons at risk for HIV survey.
- **Individual level HIV Risk Reduction Counseling (ILRRC):** Counseling an individual on methods to reduce risk of becoming infected with HIV and reducing the likelihood of transmitting HIV.
- **Linkage:** the act of connecting clients and patients to medical and support services.
- **Man who has sex with a man (MSM):** Men who engage in sexual contact with other men
- **Medicaid Expansion:** Funding to expand Medicaid programs to cover individuals up to 133% of the federal poverty line.
- **Medical Care:** Specialized medical attention for persons living with HIV.
- **Michigan Behavioral Risk Factor Surveillance System (BRFSS):** The Michigan Behavioral Risk Factor Surveillance System is an annual, state-level telephone survey of Michigan residents, age 18 to 64 years. These annual, state-level surveys, act as the only source of state-specific, population-based estimates of the prevalence of various behaviors, medical conditions, and preventive health care practices among Michigan adults
- **Michigan Department of Health and Human Services (MDHHS):** A department that combines the programs of the Michigan Department of Health and Human Services and Department of Human Services.
- **Mobilizing for Action through Planning and Partnerships (MAPP) Forces of Change Model:** According to the National Association of County and City Health Officials (NACCHO), MAPP is a community-driven strategic planning process for improving community health.
- **Needs Assessment:** A systematic process for determining need in an area
- **Non Health Care Setting:** A setting which does not provide both medical diagnostic and treatment services. Also known as a nonclinical setting.
- **Opioid:** A pain medication that reduces the intensity of pain signals reaching the brain.
- **Opioid Substitution Therapy:** Refers to naloxone, a replacement drug administered in a clinical system
- **Outstate:** Refers to the counties in Michigan that do not include the Detroit metropolitan area (Wayne, Lapeer, Macomb, Oakland, St. Clair, and Monroe counties).
- **Partner Services:** A confidential, voluntary program that works with individuals with HIV or other STIs to notify partners of their exposure.
- **PLWHA:** Persons living with HIV/AIDS
- **PrEP/PEP:** Pre-exposure prophylaxis; medication taken to prevent contracting HIV.
- **Prevalence:** The proportion of the population infected with HIV.
- **Prevention Continuum:** A five stage model used to illustrate the series of stages a high risk, uninfected individual engages in from initial identification of high risk behaviors through successful continuation of an HIV negative status. The stages include uninfected individuals with

high risk behaviors, the identification of individuals at high risk, linkage to risk reduction services, retention in risk reduction services, and continued HIV negative status.

- **Prevention:** Refers to the prevention of becoming HIV positive or preventing transmission
- **Queer:** A broad term that refers to homosexuality.
- **Referral:** A service organizations provide to connect clients or patients to other organizations that meet their need.
- **Ryan White:** A program that works with cities, states and local community-based organizations to provide services to individuals who do not have sufficient health care coverage or financial resources to cope with HIV. The program is named after an American teenager from Indiana who was expelled from middle school because of his HIV infection.
- **Ryan White Part A:** Provides assistance to Eligible Metropolitan Areas (EMAs) and Traditional Grant Areas (TGAs), areas that are more severely affected by the HIV/AIDS epidemic.
- **Ryan White Part B:** Provides grants to States and U.S. Territories; includes a base grant, the AIDS Drug Assistance Program (ADAP) award, ADAP supplemental grants, grants to States for Emerging Communities, and an award for Minority AIDS Initiative activities. Grantees are State departments of health or other State entities responsible for implementing and managing state public health programs.
- **Ryan White Part C Early Intervention Services (EIS):** Funds comprehensive primary health care in outpatient settings for persons living with HIV.
- **Ryan White Part C Capacity Development Grants:** Assists public and nonprofit entities in efforts to strengthen their organizational infrastructure and capacity to develop, enhance, or expand access to high-quality HIV primary health-care services for people living with HIV/AIDS or at risk of infection in underserved or rural communities.
- **Ryan White Part D:** Provides outpatient or ambulatory family-centered primary medical care for women, infants, children, and youth with HIV/AIDS. Funds both family-centered primary and specialty medical care and support services.
- **Same gender loving:** An individual who is attracted to or intimate with another person of the same gender.
- **Substance Abuse and Mental Health Services Administration (SAMHSA) National Survey on Drug Use and Health (NSDUH):** Provides national and state-level data on the use of tobacco, alcohol, illicit drug use (including non-medical use of prescription drugs), and mental health in the United States
- **Sex Workers:** An individual who has sex for pay
- **Support Services:** Services other than medical care that support the daily living needs of individuals.
- **Themes and Strengths:** Assessment that collects data on persons living with HIV and at risk for HIV to determine prevention and care needs
- **Viral Load:** Achieving viral suppression is defined as having an HIV viral load of less than 200 copies per milliliter. Suppressed levels of HIV allow people living with HIV to live longer and healthier lives and decreases the likelihood of transmitting HIV to others.
- **Youth Risk Behavior Survey (YRBS):** Conducted every other year in Michigan by the Department of Education and assesses a broad range of health practices among a representative sample of the state's students in grades nine through twelve.

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APPENDIX ORGANIZATIONAL ASK LETTER

DATE

Dear [ORGANIZATION]

The Michigan Public Health Institute (MPHI) has been contracted by the Michigan Department of Health and Human Services (MDHHS) to conduct a coordinated statewide HIV/AIDS needs assessment. This coordinated needs assessment is a requirement of both the Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA). The data collected during this assessment will enable HIV/AIDS planning bodies throughout Michigan, such as the MDHHS, the Detroit Department of Health and Wellness, the Michigan HIV/AIDS Council (MHAC) and the Southeastern Michigan HIV/AIDS Council (SEMHAC), to better address the needs of persons within the Michigan HIV/AIDS community that are at-risk for HIV infection and for the medical and service providers who help them. In order to facilitate data collection for this project, we would like to recruit patients and/or clients who are HIV positive and HIV negative as well as to recruit medical professionals and service providers who work with these populations from your organization.

At your organization we would like to conduct [5-15] in-person interviews with patients and/or clients who are HIV positive and [4-5] who are HIV negative, all in a private room. Each interview will take approximately 30 to 45 minutes and they will receive a \$20.00 gift card for their time. We will collect two (2) paper or online surveys from medical professionals and/or service providers, which will take 15 to 20 minutes to complete.

Can we count on your help by assisting MPHI to recruit at your organization? We would like to collect the patient and/or client data on [DATE] at [TIME]. If this date and/or time do not work for you, please contact us at HIVsurvey@mphi.org or 517-324-8378, for a date and time that will work best for you.

An invitation letter, consent form, paper survey and a link to the electronic version of the medical professional and service provider surveys will be mailed to you within the week along with enclosed postage-paid envelopes.

We thank you for your consideration and assistance on a project that will improve the health and lives of Michigan residents. If you have any specific questions about this study, please feel free to contact Dr. Crystal Pirtle Tyler at (517) 324-8378.

Looking forward to working with your organization.

Sincerely,



APPENDIX PATIENT INTERVIEW CONSENT FORM

The Michigan Public Health Institute invites you to be a part of a needs assessment of persons who may be at risk for HIV infection or who are infected with HIV in Michigan. The information below will help you decide if participating in this survey is right for you.

Why We Are Doing This Project

The purpose of this research project is to learn about the experiences of those at-risk or currently infected with HIV. The information that you provide will help organizations such as the Michigan Department of Health and Human Services (MDHHS), the Michigan HIV/AIDS Council (MHAC), the Southeastern HIV/AIDS Council (SEMHAC), the Detroit Department of Health and Wellness Promotion and others to improve access to and the quality of prevention and care programs for people throughout Michigan.

What Will Happen

You will have two choices to complete the survey in a private location. One option is to allow a trained staff member to administer the survey in an interview format, or if you prefer, you may complete the survey in private while the trained staff member is present to answer any questions or assist you. The survey has questions about your health status and your prevention and care needs. This survey will take about 30-45 minutes depending on your responses. We will write down your answers but your voice will not be audio recorded.

Things to consider

The survey is completely voluntary and there are minimal risks for participating. Some of the questions in the survey ask about sexual practices and drug use and may make you feel uncomfortable. You don't have to answer specific questions if you don't want to. The information you provide will not affect your ability to receive services from the agency that referred you.

Benefits

There are no direct benefits from your participation in this survey; however, the things we learn from this survey can help to improve HIV prevention and care programs for people throughout Michigan. In exchange for your time, we will provide a \$20 gift card upon completion of the survey.

Persons to Contact

This needs assessment is led by Dr. Crystal Tyler from the Michigan Public Health Institute. Her contact number is (517) 324-7393 and you may call her with any questions about participating in the study. If you have questions about your rights as a participant, or feel that you have been harmed, please contact the Michigan Public Health Institute Office of Research Integrity at (517) 324-7387. You will get a copy of this form to keep if you would like one.

Confidentiality Statement

Data from this survey is confidential. Your responses will be labeled with a study ID only. The study staff at the Michigan Public Health Institute will have access to the survey. Your responses will be grouped with survey answers from other participants, and you will not be identified.

Agreement

By continuing, you are indicating that you have been given the opportunity to discuss any questions that you might have and refuse participation. You will be given a copy of this letter for your records.

APPENDIX MEDICAL PROFESSIONALS AND SERVICE PROVIDER CONSENT FORM

You are being asked to participate in a research survey about the experiences of medical professionals and providers who offer services to persons living with HIV in Michigan. Information from this survey will help organizations such as the Michigan Department of Health and Human Services (MDHHS), the Michigan HIV/AIDS Council (MHAC), the Southeastern HIV/AIDS Council (SEMHAC), the Detroit Department of Health and Wellness Promotion and others to improve access to and the quality of prevention and care programs for people throughout Michigan.

Your participation will include participating in a 30 minute online or written survey. Your participation is completely voluntary and you may end your participation at any time, or you may choose not to answer specific questions that make you feel uncomfortable.

The study is not expected to cause any physical harm. The potential risks are minimal, and are mainly limited to the imposition of time. There is also the potential for emotional distress associated with the discussion of sensitive topics. You may not directly benefit from participation; however, your responses will contribute to an improved understanding of the experiences of persons providing care and services to individuals living with HIV in Michigan.

Everything we learn about you and your organization in this survey will be kept confidential and we will not identify you or your organization, or include any information that could identify you personally in any reports resulting from this survey. The information from this survey will be summarized and combined with other respondents who provide services for persons living with HIV.

The data will only be accessible to the research staff and the Michigan Public Health Institute Office of Research Integrity.

If you have questions or concerns about this survey, please contact Dr. Crystal Tyler (517) 324-7393, ctyler@mphi.org. If you have questions or concerns about your role and rights as a participant, or would like to register a complaint about this survey, you may contact, the Michigan Public Health Institute Office of Research Integrity at 517-324-7387.

By continuing with this survey, you are indicating that you agree to participate in this survey. You may retain this letter for your records.

APPENDIX MICHIGAN HIV NEEDS ASSESSMENT PATIENT SURVEY

To keep your responses confidential, we would like to have you create your own unique study ID. Please answer the following questions:

1. What are the first two letters of your high school's name? _____ (e.g., Flint Southwestern = FL)
2. What day of the month were you born? _____ (e.g., the 7th = 07)
3. What is the last letter of your first name? _____ (e.g., Tyler = R)

Combine your responses from 1-3 in order here (e.g., FL07R): _____ (this is your study ID!)

Have you completed this survey before? Yes _____ No _____

[Interviewer note: this section is to be asked of ALL respondents]

Section I. Demographics

1. What is your current age?
_____ years
2. What is your current gender (please select all that apply)?
 - a. Male
 - b. Female
 - c. Transmale/Transman
 - d. Transfemale/Transwoman
 - e. Genderqueer
 - f. Other (specify): _____
 - g. Decline to state
3. What sex were you assigned at birth?
 - a. Male
 - b. Female
4. How would you describe your sexual identity?
 - a. Heterosexual/Straight
 - b. Man who has sex with a man/Gay
 - c. Woman who has sex with a woman/Lesbian
 - d. Same gender loving
 - e. Queer
 - f. Bisexual
 - g. Other
5. With what race do you identify?

- a. White
 - b. Black/African American
 - c. Asian
 - d. Native Hawaiian/Pacific Islander
 - e. American Indian/Alaska Native
 - f. Multiracial
 - g. Other
 - h. Unknown
6. What is your ethnicity?
- a. Hispanic/Latino
 - b. Arab/Chaldean
 - c. Other (please specify): _____
 - d. Unknown
 - e. None
7. What city and county do you currently live in?
- City: _____
- County: _____
8. During the past 12 months, where did most of your money or financial support come from?
- a. Salary or wages
 - b. Savings or investments
 - c. Pension or retirement fund
 - d. Unemployment compensation
 - e. Supplemental security income (SSI) or social security disability insurance (SSDI)
 - f. Other public assistance like welfare
 - g. Family or friends
 - h. No income or financial support
 - i. Other (please specify): _____
9. During the past 12 months, have you experienced any of the following housing situations? Please select all that apply.
- a. Lived on the street
 - b. Lived in any public or private shelter temporarily like a hotel or motel paid for by any government program, congregate shelters, or charitable organizations
 - c. Lived in a single room occupancy (SRO) hotel
 - d. Lived in a car
 - e. Lived in transitional housing
 - f. Lived in an abandoned building
 - g. Lived in a public place such as a park, bus or train station, airport, or camping ground
 - h. Lived with a friend or family member in a home you did not consider your home
 - i. Lived in any other unstable or non-permanent situation
 - j. Lived in a jail, prison, or correctional facility
 - k. Ever lacked a fixed, regular, adequate place to sleep at night

I. I have not experienced any of the housing situations in the past 12 months

10. During the past 12 months, what type of health care insurance have you had? Please select all that apply.

- a. Medicaid/Healthy Michigan Plan
- b. Medicare
- c. Ryan White Program
- d. Private employer supported insurance
- e. Private insurance paid through the insurance marketplace
- f. Veterans insurance coverage
- g. Other _____
- h. I did not have health insurance coverage during the past 12 months

11. Have you ever been arrested and put in a jail, detention or prison for longer than 24 hours?

- a. Yes
- b. No

12. Are you HIV positive?

- a. Yes **(go to page 4)**
- b. No **(go to page 17)**

(If answer to question #12 is YES, go to PAGE 4, Survey of Persons Living with HIV)

(If answer to question #12 is NO, go to PAGE 15, Survey of Persons at Risk for HIV)

**Michigan HIV Needs Assessment
Survey of Persons Living with HIV/AIDS**

[to be asked only to those respondents who answered YES to question #12]

Section II. Testing History

13. How old were you when you first tested positive for HIV?
_____ years

14. About how long ago did you first test positive for HIV? Would you say it was:

- a. Within the past 3 months
- b. 3 to 6 months ago
- c. 6 months to 1 year ago
- d. 1 to 5 years ago
- e. More than 5 years ago

15. Where did you first test positive for HIV?

- a. Emergency room
- b. Health department
- c. Community HIV/STD testing site
- d. Doctor's office
- e. Prison or jail
- f. Home testing kit
- g. Substance abuse treatment center
- h. Other (please specify): _____

16. There are lots of reasons why someone might get tested for HIV, what made you decide to get tested for HIV at that time? Please check all that apply.

- a. I was concerned because I had unprotected sex
- b. I was concerned because I had injected drugs with a needle
- c. I was testing for other sexually transmitted diseases (STD)
- d. I felt sick or had an illness (other than an STD)
- e. I was pregnant
- f. I was getting a routine HIV test
- g. A health care provider recommended I get an HIV test
- h. I was notified that my partner was HIV positive
- i. I was tested before donating blood
- j. I was tested as a needle stick follow up or occupational exposure
- k. I was required to by the military, a court order, insurance, etc.
- l. I experienced sexual assault
- m. Other (please specify) _____

Section III. HIV Behaviors

17. There are a number of ways HIV is transmitted from an infected person to another person. Which of the follow behaviors did you participate in before you were diagnosed with HIV? Please select all that apply.

- a. Vaginal (penis-vagina) sex without a condom
- b. Vaginal (penis-vagina) sex with a condom
- c. Insertive anal sex without a condom
- d. Insertive anal sex with a condom
- e. Receptive anal sex without a condom
- f. Receptive anal sex with a condom
- g. Oral sex (mouth-penis/fellatio)
- h. Oral sex (mouth-vagina/cunninglingus)
- i. Oral sex (mouth-anus/rimming)
- j. Sharing needles for drug use
- k. Sharing other works (i.e. cottons) for injecting drug use
- l. Blood transfusion/receipt of blood products
- m. Other (please specify): _____
- n. I don't know

18. Have you had sex with a non-monogamous partner?

- a. Yes
- b. No

19. Have you participated in partner services?

- a. Yes → go to #20 and continue
- b. No → go to #21 and continue

20. How would you rate your overall experience with partner services?

- a. Poor
- b. Fair
- c. Neutral
- d. Good
- e. Excellent

Section IV. Linkage to Medical Care

21. How long after you tested positive for HIV did you first see a doctor, nurse, or other health care worker for HIV medical care? Would you say it was:

- a. Less than 3 months after testing positive
 - b. 3 to 6 months after testing positive
 - c. 6 months to 1 year after testing positive
 - d. More than 1 year after testing positive
 - e. I never had HIV medical care
- } → Go to #22 and continue
- Go to #29 and continue

22. How easy or difficult was it for you to see a doctor, nurse, or other health care worker for HIV medical care that first time after you tested positive? Would you say it was:

- a. Very difficult
 - b. Somewhat difficult
 - c. Somewhat easy
 - d. Very easy
- } → Go to #23 and continue
- } → Go to #24 and continue

23. What made it the most difficult for you to get HIV medical care that first time after you tested positive?

24. What are the most important things that should be done to make it as easy as possible for people to get HIV medical care within three months of first testing positive?

Section V. Case Management and Other Support Services

25. Now I want to ask you some questions about services you may have needed other than HIV medical care. Did you ever get help from someone whose job it was to assist you with other things you may have needed to help take care of your HIV, like finding an HIV doctor, transportation, housing, food, or other things like that?

- a. Yes →
- b. No → Go to #27 and continue

26. How long after you tested positive for HIV did you first get connected with someone whose job it was to help you with these kinds of things?

- a. Less than 3 months after I tested positive
- b. 3 to 6 months after I tested positive
- c. 6 months to 1 year after I tested positive
- d. More than a year after I tested positive

27. What do you think are the most important things that should be done after someone first tests positive for HIV to help them connect with someone whose job it is to help with other things they may need, like finding an HIV doctor, transportation, housing, food or other things like that?

28. Beside HIV medical care, are there any other services you have needed in the past 12 months?

Please select all that apply.

- a. HIV case management services
- b. Counseling about how to prevent the spread of HIV
- c. Medicine through the AIDS Drug Assistance Program (ADAP)
- d. Professional help remembering to take my HIV medicines on time or correctly
- e. HIV peer group support
- f. Dental care
- g. Mental health services
- h. Drug or alcohol counseling or treatment
- i. Supplemental Security Income (SSI)/Social Security Disability Insurance (SSDI)
- j. Domestic violence services
- k. Shelter or housing services
- l. Meal or food services
- m. Home health services

- n. Transportation assistance
- o. Childcare services
- p. Interpreter services
- q. Nutritional Services
- r. Insurance enrollment assistance
- s. Other (please specify): _____
- t. None

Section VI. Retention in Care

29. Now I want to ask you some more questions about HIV medical care. How easy or difficult is it for you to see a doctor, nurse, or other health care worker for HIV medical care now?

- a. Very difficult
 - b. Somewhat difficult
 - c. Somewhat easy
 - d. Very easy
- } —→ Go to #30 and continue
- } —→ Go to #31 and continue

30. What makes it difficult for you to get HIV medical care now?

31. What helps you get HIV medical care now?

32. In the past two years, has there been a time when you did not see a doctor, nurse, or other medical care worker for HIV medical care for 12 months or longer?

- a. Yes —→
- b. No —→ Go to #35 and continue

33. In the past two years, has there been a time when you did not see a doctor, nurse, or other health care worker for HIV medical care for 6 months or longer?

- a. Yes —→
- b. No —→ Go to #35 and continue

34. Over the past two years, what has helped you to stay in HIV medical care without stopping or taking a break?

(Skip to question #38 after answering this question and continue)

35. I am going to read you a list of reasons why someone may stop or take a break from getting HIV medical care. Please tell me the main reasons you did not see a doctor, nurse, or other health care worker for HIV medical care during that time? Please select all that apply.

- a. I didn't want to think about being HIV positive
- b. My doctor told me I only needed to go once a year
- c. My CD4 count and viral load were good
- d. I felt fine and didn't think I needed to go
- e. I didn't know where to go
- f. I was unable to get an appointment

- g. I forgot or missed my appointment
- h. I felt too sick to go
- i. I was unable to get transportation
- j. I had other responsibilities such as child care or work
- k. I didn't have enough money or health insurance
- l. I was homeless or did not have a steady place to live
- m. I was drinking or using drugs
- n. I didn't feel comfortable going there
- o. I didn't like the way I was treated
- p. I was incarcerated
- q. Stigma related to HIV
- r. Other (please specify): _____

36. Did you start getting HIV medical care again after you stopped during that time?

- a. Yes → Go to #37 and continue
- b. No → Go to #38 and continue

37. What helped you the most to get reconnected with HIV medical care?

38. What do you think are the most important things that should be done to help someone stay in HIV medical care without stopping or taking a break?

Section VII. Treatment Adherence

39. Are you currently prescribed any HIV medications?

- a. Yes → Go to #40 and continue
- b. No → Go to #44 and continue

40. In the past 30 days, have you skipped or missed a dose of your HIV medication(s), other than being told to do so by a doctor, nurse, or other health care worker??

- a. Yes
- b. No

41. In general, how easy or difficult is it for you to take all of your HIV medications without skipping or missing any doses? Would you say it is:

- | | | |
|-----------------------|---|--------------------------|
| a. Very difficult | } | → Go to #42 and continue |
| b. Somewhat difficult | | |
| c. Somewhat easy | } | → Go to #43 and continue |
| d. Very easy | | |

42. What makes it the most difficult for you to take all of your HIV medications without skipping or missing any doses?

43. What are the most important things that help you take your HIV medications without skipping or

missing any doses?

Section VIII. Management of HIV Infection

44. How would you rate yourself with the management of your HIV infection?

- a. I do not manage my HIV infection at all
- b. I manage my HIV infection poorly
- c. I manage my HIV infection okay
- d. I manage my HIV infection well
- e. I'm not sure how I manage my HIV infection

45. Since you tested positive for HIV, which of the following have been challenges for you? Please select all that apply.

- a. Paying my medical bills
- b. Maintaining insurance coverage
- c. Paying copays for prescription drugs
- d. Finding an HIV doctor near me
- e. Getting to my doctor's appointments or to other HIV services
- f. Finding employment or staying employed
- g. Accessing clean/sterile needles/works
- h. Abusing alcohol/drugs
- i. Practicing/maintaining safer sex
- j. Having access to condoms
- k. Finding support for my children
- l. Maintaining stable housing, such as paying rent, mortgage, and/or utility bills
- m. Having access to food and/or feeding my family
- n. Feeling confident that I won't infect others
- o. Telling my sex partners about my HIV status
- p. Telling friends/family about my HIV status
- q. Talking about healthy relationships
- r. Meeting people that I can relate to
- s. Meeting other HIV positive people
- t. Feeling that I am trapped, damned, or doomed
- u. Other (please specify): _____

Section IX. Viral suppression

46. When was the last time that you had a viral load test?

- | | | | |
|---------------------------------------|---|---|------------------------|
| a. Within the past year | } | → | Go to #47 and continue |
| b. 1 to 2 years ago | | | |
| c. 3 to 4 years ago | | | |
| d. 5 or more years ago | | | |
| e. I have never had a viral load test | } | → | Go to #48 and continue |

47. Have you been told that you are virally suppressed (had less than 200 viral copies in a milliliter)?

- a. Yes
- b. No
- c. I don't know

Section X. Satisfaction with care

48. Which of the following should HIV care providers do to serve you better? Please select all that apply.
- a. Be more experienced/knowledgeable about providing HIV care
 - b. Know what HIV-related services are available in my area and provide referrals
 - c. Have better office hours that are more convenient for me
 - d. Reduce the wait time to get an appointment
 - e. Make appointments quicker
 - f. Provide services in a location that are easier for me to get to
 - g. Advocate for my needs within the service system
 - h. Know how to work with people from other cultures
 - i. Know how to work with people from the LGBTQ community, including transgender individuals
 - j. Know a language other than English
 - k. Other (please specify): _____
49. What is the single most important change that you would suggest to improve services for individuals or families living with HIV?

Section XI. Prevention services

50. There are a number of intervention programs that assist persons living with HIV and at risk for HIV with reducing their high risk behaviors. Which of the following programmatic topics would you like to learn more about?
- a. Stress reduction
 - b. How to use condoms or dental dams
 - c. Reducing my number of sexual partners
 - d. Maintaining a monogamous relationship
 - e. How to disclose my HIV status to a sexual partner
 - f. How to disclose my HIV status to family members or friends
 - g. How to talk to my partner(s) about healthy relationships
 - h. How to access medical care and support services
 - i. How to avoid drug use
 - j. How to avoid alcohol use
 - k. How to feel better about myself and my HIV status
 - l. Skill building on how to reduce the spread of HIV and STDs
 - m. Skill building on medication adherence
 - n. How to practice safer sex in general
 - o. Other: _____
 - p. I don't need to learn about any of these topics
51. Have you ever participated in any of the below HIV individual, group, or linkage prevention programs? Please select all that apply.
- a. The group program "Healthy Relationships"
 - b. The linkage program "Anti-retroviral Treatment and Access to Services (ARTAS)"
 - c. The group program "Mpowerment"
 - d. The individual program "Individual Level HIV Risk Reduction Counseling (ILRRC)"
 - e. The group program "Prevention Options for Positives" (POP)
 - f. Other similar programs: _____
 - g. I don't know

52. Would you be interested in participating in group intervention activities with other individuals from the following groups?

- a. Persons living with HIV
- b. Men who have sex with men
- c. Youth
- d. Transgender population
- e. Other: _____
- f. I am not interested in participating in group intervention activities

Section XI. Prevention knowledge

53. Have you heard about a pill that someone who does not have HIV can take daily to prevent becoming infected with HIV?

- a. Yes → Go to #54 and continue
- b. No → Go to the end of the survey

54. Do you know anyone who is taking a pill every day to prevent becoming infected with HIV or taking PrEP?

- a. Yes
- b. No

55. Would you feel comfortable encouraging a friend who is at risk for HIV to consider taking a pill every day to prevent becoming infected with HIV or taking PrEP?

- a. Yes
- b. No

56. Where would you tell someone to go if they wanted to get on a pill to prevent becoming infected with HIV or PrEP?

- a. I don't know
- b. Please specify: _____

This concludes our survey. Thank you for your time!

**Michigan HIV Needs Assessment: Themes & Strengths
Survey of Persons at-risk for HIV Infection**

[to be asked to only those respondents who answered NO to question #12]

Section II. Testing History

13. Have you ever been tested for HIV?

- a. Yes \longrightarrow Go to #14 and continue
- b. No \longrightarrow Go to #17 and continue

14. When was the last time you were tested for HIV?

- a. Within the past year
- b. 1 to 2 years ago
- c. 3 to 4 years ago
- d. 5 or more years ago

15. Where did you get your last HIV test?

- a. Emergency room
- b. Health department
- c. Community HIV/STD testing site
- d. Doctor's office
- e. Prison or jail
- f. Home testing kit
- g. Substance abuse treatment center
- h. Other (please specify): _____

16. There are lots of reasons why someone might get tested for HIV, what made you decide to get your most recent HIV test? Please select all that apply.

- a. I was concerned because I had unprotected sexual contact
- b. I was concerned because I had injected drugs with a needle
- c. I was testing for other sexually transmitted diseases (STD)
- d. I felt sick or had an illness (other than an STD)
- e. I was pregnant
- f. I was getting a routine HIV test
- g. A health care provider recommended I get an HIV test
- h. I was notified that my partner was HIV positive
- i. I was tested before donating blood
- j. I was tested as a needle stick follow up or occupational exposure
- k. I was required to from the military, a court order, insurance, etc.
- l. I experienced sexual assault
- m. Other (please specify): _____

Go to #18 and continue

17. Under what circumstances would you consider being tested for HIV? Please select all that apply.

- a. If I was concerned after having unprotected sexual contact
- b. If I was concerned after injecting drugs with a needle
- c. If I was tested for other sexually transmitted diseases (STDs)
- d. If I felt sick

- e. If I was pregnant
- f. If a provider recommended it as part of routine care
- g. If I was notified that my partner or someone I had sexual contact with had HIV
- h. Before donating blood
- i. As a needle stick follow up or occupational exposure
- j. As a requirement from the military, a court order, insurance, etc.
- k. If I experienced sexual assault
- l. Other: _____

18. Have you gone to do the doctor in the past year for a non-emergency visit?

- a. Yes → Go to #19 and continue
- b. No → Go to #20 and continue

19. At your last doctor's appointment, did your doctor or nurse offer you an HIV test?

- a. Yes
- b. No

Section III. Behaviors

20. Which of the following have you participated in? Please select all that apply.

- a. Vaginal (penis-vagina) sex without a condom
- b. Vaginal (penis-vagina) sex with a condom
- c. Insertive anal sex without a condom
- d. Insertive anal sex with a condom
- e. Receptive anal sex without a condom
- f. Receptive anal sex with a condom
- g. Oral sex (mouth-penis/fellatio)
- h. Oral sex (mouth-vagina/cunninglingus)
- i. Oral sex (mouth-anus/rimming)
- j. Injecting drugs that were not prescribed to me by a physician
- k. Sharing needles for drug use
- l. Sharing other works (i.e. cottons) for injecting drug use
- m. Blood transfusion/receipt of blood products
- n. Other (please specify): _____
- o. I don't know

21. Have you had sex with a non-monogamous partner?

- a. Yes
- b. No

Section IV. Prevention Knowledge

22. Have you ever received HIV prevention education or sexually transmitted infection prevention education?

- a. Yes → Go to #23 and continue
- b. No → Go to #24 and continue

23. In what setting did you receive HIV prevention education or sexually transmitted infection prevention education?

- a. School
- b. Community based organization

- c. Medical setting
- d. Other (please specify): _____

24. Have you heard of partner services for people with HIV and/or STIs?

- a. Yes
- b. No → Go to #27 and continue

25. Have you participated in partner services?

- a. Yes
- b. No → go to #27 and continue

26. How would you rate your overall experience with partner services?

- a. Poor
- b. Fair
- c. Neutral
- d. Good
- e. Excellent

27. There are a number of intervention programs that assist persons at risk for HIV with reducing their high risk behaviors. Which of the following programmatic topics would you like to learn more about?

- a. How to talk to my partner about HIV and STDs
- b. Stress reduction
- c. How to use condoms or dental dams
- d. Reducing my number of sexual partners
- e. Maintaining a monogamous relationship
- f. How to access medical care and support services
- g. How to avoid drug use
- h. How to avoid alcohol use
- i. Skill building on how to reduce the spread of HIV and STDs
- j. Other: _____
- k. I'm not interested in programs on any of these topics

28. What do you think is the most important thing someone can do to keep from getting HIV?

29. Have you heard about a pill that someone who does not have HIV can take daily to prevent becoming infected with HIV?

- a. Yes
- b. No

30. PrEP is when a person who does not have HIV, but is at risk for it, takes a special pill every day to prevent HIV infection. Would you feel comfortable talking to your doctor about a pill that you could take daily to prevent HIV?

- a. Yes
- b. No

31. Would you consider taking PrEP if you and your doctor felt it was right for you?
- a. Yes → Go to #33 and continue
 - b. No → Go to #32 and continue
32. Why would you not consider taking PrEP?
- a. It is too expensive
 - b. I don't know where to get it
 - c. It is too hard to get
 - d. I worry about the side effects
 - e. I don't think that it is safe to take
 - f. I don't think that it works
 - g. Someone might find out I was taking it
 - h. I don't think it is right for me
 - i. I am not at risk for HIV
 - j. Other (please specify): _____
33. Would you feel comfortable encouraging a friend who is at risk for HIV to consider taking PrEP?
- a. Yes
 - b. No
34. Do you currently know anyone who is on PrEP?
- a. Yes
 - b. No
35. Would you trust a pill like PrEP to protect you from becoming infected when having sex with someone with HIV?
- a. Yes
 - b. No
36. Do you think it would be worth it to take a pill every day to not worry about getting HIV?
- a. Yes
 - b. No
37. Where would you tell someone to go that wanted to get on PrEP?
- a. I don't know
 - b. Please specify: _____

This concludes our survey. Thank you for your time!

APPENDIX MEDICAL PROFESSIONALS AND SERVICE PROVIDERS

To keep your responses confidential, we would like to have you create your own unique study ID. Please answer the following questions:

1. What are the first two letters of your high school's name? ____ (e.g., Flint Southwestern = FL)
2. What day of the month were you born? ____ (e.g., the 7th = 07)
3. What is the last letter of your first name? ____ (e.g., Tyler = R)

Combine your responses from 1-3 in order here (e.g., FL07R): _____ (this is your study ID!)

Have you completed an electronic or paper version of this survey before? Yes ____ No ____

Section I. Demographics

1. Do you provide medical care, dental care, prevention services or treatment services to persons living with HIV as part of your job?
 - a. Yes
 - b. No (**please skip to the end of the survey**)
2. What is your profession?
 - a. Physician
 - b. Physician Assistant
 - c. Advanced Practice Nurse
 - d. Nurse Practitioner
 - e. Nurse
 - f. Dentist
 - g. Other Dental Professional
 - h. Dietitian/Nutritionist
 - i. Case Manager
 - j. Clinical Pharmacist
 - k. Mental Health Provider
 - l. Substance Use Professional
 - m. Social Worker
 - n. Peer Counselor/Advocate
 - o. Health Educator
 - p. Administrator
 - q. Psychiatrist
 - r. Other (please specify) : _____
3. What certifications do you have?

- a. Board certified: Internal Medicine
 - b. Board certified: Family Practice
 - c. Board certified: Pediatrics
 - d. Board certified: Infectious Diseases
 - e. Board certified: Obstetrics and gynecology
 - f. Board certified: Emergency medicine
 - g. AIDS Certified Registered Nurse (ACRN)
 - h. Advanced AIDS Certified Registered Nurse (AACRN)
 - i. American Academy of HIV Medicine (AAHIVM)
 - j. Other board certification (please specify): _____
 - k. None
4. What is your current gender? Please select all that apply.
- a. Male
 - b. Female
 - c. Transmale/Transman
 - d. Transfemale/Transwoman
 - e. Genderqueer
 - f. Additional Category: _____
 - g. Decline to state
5. What sex were you assigned at birth?
- a. Male
 - b. Female
6. How would you describe your sexual identity?
- a. Heterosexual/Straight
 - b. Man who has sex with a man
 - c. Woman who has sex with a woman/Lesbian
 - d. Same gender loving
 - e. Queer
 - f. Bisexual
 - g. Other
7. What race do you identify as?
- a. White
 - b. Black/African American
 - c. Asian
 - d. Native Hawaiian/Pacific Islander
 - e. American Indian/Alaska Native
 - f. Multiracial/Other/Unknown
8. What is your ethnicity?
- a. Hispanic/Latino
 - b. Arab
 - c. Chaldean
 - d. None
 - e. Other (please specify): _____

f. Unknown/Not Applicable

9. How long have you worked in your current field?

- a. <1 year
- b. 1-5 years
- c. 6-10 years
- d. 11+ years

Section II. Description of Organization

10. In which type of setting do you provide care or services for persons living with HIV/AIDS? Please select all that apply.

- a. Community health center
- b. Hospital based practice
- c. Urgent care or emergency medicine facility
- d. Group private practice
- e. HIV/AIDS clinic
- f. Solo private practice
- g. University health center
- h. Veterans Affairs hospital
- i. Federally Qualified Health Center
- j. AIDS Service Organization
- k. Community based organization
- l. Health department
- m. Other (please specify): _____

11. What is the name of your organization?

12. In what city is your organization located?

13. In what county is your organization located?

14. Does your organization provide translation services?

- a. Yes —> Go to number 15 and continue
- b. No —> Go to number 16 and continue

15. In what languages are services provided? Please select all that apply.

- a. English
- b. Spanish
- c. Arabic
- d. Other: _____

16. Approximately how many patients/clients with HIV does your organization currently provide care/services to?

17. Approximately what proportion of your clients/patients have HIV?

- a. Less than 10%
- b. 11-25%
- c. 26-50%

d. More than 50%

18. Approximately how many patients/clients with HIV has your organization provided care/services to during the past 5 working days?

19. Since the implementation of the Healthy Michigan Plan/Medicaid expansion in April 2014, how has the demand for your organization's services changed among persons living with HIV?

- a. Demand increased
- b. Demand remained the same
- c. Demand decreased
- d. I don't know

20. Has your organization experienced any burdens due to the implementation of the Affordable Care Act or Medicaid expansion?

- a. Yes
- b. No

21. Please describe the burden experienced due to the implementation of the Affordable Care Act or Medicaid Expansion.

Section III. Provider comfort with discussing HIV

22. Do you discuss topics related to HIV transmission with your patients/clients?

- a. Yes → Go to number 23 and continue
- b. No → Go to number 24 and continue

23. How comfortable are you discussing topics related to HIV transmission with the following groups of individuals?

Population	Very comfortable	Moderately comfortable	Not very comfortable	I do not interact with this population
Persons living with HIV				
Men who have sex with men				
Substance user/chemical dependents				
Medicaid eligible				
Racial/ethnic minorities				
Men				
Women				
Adolescents (13-19 years)				
Children (0-12 years)				
Transgender persons				
Sex workers				
Persons with limited English proficiency				

24. Do you discuss topics related to HIV care with your patients/clients?

- a. Yes → Go to number 25 and continue
- b. No → Go to number 26 and continue

25. How comfortable are you discussing topics related to HIV care with the following groups of individuals?

Population	Very comfortable	Moderately comfortable	Not very comfortable	I do not interact with this population
Persons living with HIV				
Men who have sex with men				
Substance user/chemical dependents				
Medicaid eligible				
Racial/ethnic minority				
Men				
Women				
Adolescents (13-19 years)				
Children (0-12 years)				
Transgender persons				
Persons with limited English proficiency				

Section IV. Services Routinely Provided

26. Does your organization conduct HIV tests?

- a. Yes → Go to number 27 and continue
- b. No → Go to number 32 and continue

27. Which of the following tasks do you complete during a typical week related to HIV testing?

- a. I supervise staff who conduct HIV tests
- b. I administer HIV tests
- c. I conduct partner services activities for individuals who received a positive HIV test
- d. I provide health care services for patients who have received an HIV test
- e. I teach other health care providers or students about HIV testing
- f. I do not have a role with HIV testing
- g. Other (please specify): _____

28. In which situations does your organization offer an HIV test? Please select all that apply.

- a. All individuals who enter our organization are offered an HIV test
- b. Diagnostic testing among individuals with clinical signs or symptoms consistent with HIV infection
- c. Targeted testing of men who have sex with men

- i. Provide early intervention services or other specific linkage to care services
 - j. Accompany patients/clients to appointments
 - k. Provide translation services
 - l. Other (please specify): _____
35. What are the most significant barriers that your organization faces when facilitating linkage to care for patients/clients with HIV? Please select up to three barriers.
- Internal practice/agency staff barriers*
- a. Limited staff knowledge/skill/experience
 - b. Limited staff time
 - c. No established procedure or protocol in place
 - d. Limited amount of dedicated funding
 - e. Inability to be reimbursed for linkage services
 - f. Leadership resistance to providing this service
 - g. Staff resistance to providing this service
 - h. Staff cultural competency/comfort with issue
 - i. Unsure where to refer patients/clients
 - j. Difficult to get clients into specialty care
- Receiving practice/agency staff barriers*
- k. Staff knowledge/skills/experience
 - l. Staff time
 - m. Limited amount of dedicated funding
- Other barriers*
- n. Patient/client resistance
 - o. Services are not available in our area (please specify service): _____
 - p. Other (please specify): _____
36. Does your organization facilitate the linkage of HIV positive patients/clients to support services?
- a. Yes →
 - b. No → Go to number 38 and continue
37. What does your organization do to link HIV positive patients/clients to support services? Please select all that apply.
- a. Provide referrals to specific providers
 - b. Refer patients/clients internally for support services
 - c. Schedule appointments for patients/clients
 - d. Provide patients/clients with a list of local providers/services
 - e. Provide reminders about up-coming appointments
 - f. Confirm that the patient/client attended the appointment
 - g. Provide transportation assistance
 - h. Provide case management services
 - i. Provide early intervention services or other specific linkage to care services
 - j. Accompany patients/clients to appointments
 - k. Provide translation services
 - l. Other (please specify): _____

Section VI. Provision of Medical, Dental and Support Services

38. Does your organization provide medical, dental or support services to persons living with HIV?

- a. Yes →
- b. No → Go to number 42 and continue

39. Which of the following do you complete during a typical week with/for persons living with HIV?

Please select all that apply.

- a. Provide medical treatment for patients/clients living with HIV
- b. Provide dental care for patients/clients living with HIV
- c. Provide mental health or substance abuse treatment for patients/clients living with HIV
- d. Provide evidence based interventions for patients/clients living with HIV
- e. Link patients/clients living with HIV to medical or support services
- f. Provide stress reduction techniques
- g. Teach patients/clients how to use condoms or dental dams
- h. Teach patients/clients how to reduce their number of sexual partners
- i. Teach patients/clients how to discuss having a healthy relationship with their partner
- j. Teach patients/clients how to disclose their HIV status to a sexual partner
- k. Teach patients/clients how to disclose their HIV status to family members or friends
- l. Teach patients/clients how to feel better about themselves and their HIV status
- m. Provide skill building on medication adherence
- n. Other (please specify): _____

40. How confident are you in the following areas when providing care or services to your patients/clients with HIV?

Medical, dental or support service	I do this activity			I don't do this activity
	Very Confident	Moderately Confident	Not very Confident	
Communicating HIV risk and transmission				
Assessing patient/client substance use/abuse				
Assessing patient/client sexual risk				
Providing evidence-based group HIV prevention interventions				
Providing evidence-based individual HIV prevention interventions				
Providing dental screening and care				
Providing long-term HIV care				
Providing general medical care unrelated to HIV				
Treating chronic hepatitis				
Assessing when to begin therapy				
Managing ART adverse effects				
Assessing patient adherence to drug regimens				
Remaining up-to-date with advances in HIV care				

41. What are the most significant barriers that your organization faces when providing services to persons living with HIV? Please select up to three barriers.

- a. Lack of staff time to provide services

- b. Lack of referral partners for services not offered in our organization
- c. Limited reimbursement for services
- d. Lack of available providers proficient in the provision of HIV care
- e. Lack of providers who are comfortable communicating with patients/clients with HIV
- f. Lack of providers who are proficient in the provision of evidence based interventions for persons living with HIV
- g. Stigma or avoidance of HIV issues among staff
- h. Lack of cultural competency when communicating with patients/clients who are LGBTQ
- i. Insurance coverage concerns
- j. Prior authorization concerns
- k. Fail-first or step therapy concerns
- l. Formulary restrictions
- m. Quantity Limits
- n. Other (please specify): _____

Section VII. Provision of HIV prevention and medication

42. In your current role, do you prescribe patients/clients medications that prevent HIV infection or treat current HIV infections?
- a. Yes → Go to number 42 and continue
 - b. No → Go to number 47 and continue
43. Have you ever prescribed continuous daily dosing of tenofovir/emtricitabine (Truvada) for pre-exposure prophylaxis (PrEP) of HIV infection?
- c. Yes → Go to number 44 and continue
 - d. No → Go to number 45 and continue
44. For whom have you prescribed continuous daily dosing of tenofovir/emtricitabine (Truvada) for PrEP? Please select all that apply.
- a. Men who have sex with men
 - b. Men who have sex with women
 - c. Transgender women
 - d. Transgender men
 - e. Women who have sex with men
 - f. Uninfected partners in serodiscordant couples attempting to conceive
 - g. Sex workers
 - h. Injecting drug users
 - i. Other (please specify): _____
45. Have you ever prescribed antiretroviral medication for non-occupational post-exposure prophylaxis (nPEP)?
- a. Yes → Go to number 46 and continue
 - b. No → Go to number 47 and continue
46. For whom have you prescribed antiretroviral medication for nPEP? Please select all that apply.
- a. Men who have sex with men
 - b. Men who have sex with women
 - c. Transgender women

- d. Transgender men
- e. Women who have sex with men
- f. Uninfected partners in serodiscordant couples attempting to conceive
- g. Injecting drug users
- h. Sex workers
- i. Survivors of sexual assault
- j. Other (please specify): _____

Section VIII. New patient wait times

47. Are you currently accepting new patients/clients with HIV?
- a. Yes \longrightarrow Go to number 48 and continue
 - b. No \longrightarrow Go to number 49 and continue
48. What's the approximate wait time for new patients with HIV to get an appointment in your organization?
- a. Patients come in anytime they need care and don't need an appointment
 - b. <1 week
 - c. 1-2 weeks
 - d. 2 or more weeks
49. What's the approximate wait time in your organization waiting area for all patients with HIV?
- a. Less than 5 minutes
 - b. 5-10 minutes
 - c. 11-20 minutes
 - d. 21-30 minutes
 - e. 31 minutes to 1 hour
 - f. More than 1 hour

Section IX. Barriers to Care

50. What do you see as the most significant barriers for patients/clients with HIV/AIDS who are seeking services from your organization? Please select up to three barriers.
- a. Substance abuse
 - b. Mental illness
 - c. Ability to pay
 - d. HIV stigma
 - e. Lack of provider sensitivity to client/patient gender identity and/or sexuality
 - f. Housing insecurity
 - g. Transportation issues
 - h. Childcare
 - i. Location of HIV treatment centers
 - j. Patient/client non-compliance
 - k. Other (please specify): _____

X. HIV Education Needs

51. As a professional who provides care or support services to patients/clients with HIV/AIDS, which of the following would you like to learn more about? Please select all that apply.
- a. Retention in care
 - b. Antiretroviral therapy
 - c. HIV treatment education
 - d. Mental health care
 - e. PrEP/nPEP
 - f. HIV prevention counseling
 - g. HIV rapid testing
 - h. Sexual health behavioral assessments
 - i. STI screening and treatment
 - j. LGBTQ sensitivity training
 - k. Diagnosis and treatment for opportunistic infections
 - l. Management of co-infections
 - m. Opioid substitution therapy
 - n. Other (please specify): _____

XI. Opioid Safety

52. For each of the following items, please select the response that best describes your personal perspective about barriers to implementing opioid safety training with naloxone for HIV positive patients and patients at risk for HIV infection.

	Agree	Disagree	Don't Know	Not applicable to my practice
I am concerned about costs and reimbursement for training and access to naloxone rescue kits.				
My patients do not receive prescriptions for opioids and/or are not at risk of overdose.				
I am aware of screening tools for overdose risk.				
I am aware of programming to successfully address opioid overdose in my patient population.				
I am comfortable discussing opioid use and possible substance abuse with my patients.				
I am concerned my patients will not honestly discuss their opioid and other substance use with me.				

Thank you for your time!

APPENDIX SEMI-STRUCTURED INTERVIEW FOR JAILS

1. What is your process when working with HIV positive individuals while they are in jail?
2. Are you currently providing care to HIV positive individuals while they are in jail? What type of medical staff do you have “in house”?
3. Do you give HIV positive individuals medications while they are in jail? Do you send them out (once they are released) with a supply of meds?
4. Where do you send HIV Positive individuals after they leave your jail in order to continue care when they leave?
5. Are these individuals being referred to an AIDS Service Organization or CBO’s before they leave your jail?
6. If you are linking individuals to care after they are released, when do you begin to discuss these options with the individuals, while they are still incarcerated?
7. Do you have an HIV/AIDS case management program? If so, do they provide referrals to housing, medical services, transportation, and other various community social services?
8. Are these individuals given information regarding how to apply for insurance (disability/Medicaid)?
9. Do your clients talk about their experience with care in the jail?
10. Would you be interested in letting us (MDHHS) help develop a system for follow-up care after individuals are released from your jail?
11. In your opinion, is there anyone else I should talk to in order to gain a better perspective of the process of linkage to care?

APPENDIX COMMUNITY ENGAGEMENT AND SEXUAL HEALTH SURVEY

Location of Survey: _____

Date: _____

1. Is HIV/STDs a personal concern for you?

<p>How do you identify (check all that apply):</p> <p>Male</p> <p>Female</p> <p>Transgender</p> <p>___ Female to Male</p> <p>___ Male to Female</p> <p>Bi-gender</p> <p>Gay</p> <p>Straight</p> <p>Lesbian</p> <p>Bi-sexual/Bi-attracted</p> <p>Pansexual</p> <p>Queer</p> <p>Choose not to answer</p>	<p>Age: _____</p> <p>Zip: _____</p> <p>County: _____</p> <p>Race/Ethnicity (check all that apply):</p> <p>African American/Black</p> <p>Hispanic</p> <p>White</p> <p>Asian</p> <p>Multi-Cultural</p> <p>Native American/Alaskan Native</p> <p>Arab/Chaldean</p> <p>Native Hawaiian/Pacific Islander</p> <p>Choose not to answer</p>
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___ YES

___ NO

___ I have trust issues within my relationship

___ I'm not sexually active at this time.

___ I have been sexually active

___ I'm married or in a committed relationship

Other: _____

2. How often have you talked about HIV/STDs with family?

___ Often ___ Some ___ Not at all

3. How often have you talked about HIV/STDs with friends?

___ Often ___ Some ___ Not at all

4. Have you been tested for HIV?

___ YES

___ NO

___ Just wanted to know my HIV status

___ I'm afraid of finding out my HIV status

___ Starting a new relationship

___ I don't know where to go and get tested

___ Had sex without a condom

___ I already know my HIV status

___ Partner asked me to get tested

___ I don't feel I'm at risk for HIV

Other: _____

5. Has your partner(s) been tested? ___ YES NO Don't know Don't have a partner

6. Has a healthcare provider ever suggested you get a HIV test? ___ YES ___ NO

7. Has a healthcare provider talked with you about HIV/STD? ☐ YES ☐ NO
8. Have your parent(s) or guardian(s) ever talked with you about safer sex? ☐ YES ☐ NO
9. If yes to #8, how helpful was the information from your parent(s) or guardian(s) for you to make decisions about your sexual behavior?
☐ Very helpful ☐ Somewhat helpful ☐ Not helpful
10. Have you received HIV/STD prevention information in school? ☐ YES ☐ NO ☐ NA
11. If yes to #10, how helpful was the information from school for you to make decision about your sexual behavior?
☐ Very helpful ☐ Somewhat helpful ☐ Not helpful
12. Have you heard of PrEP (PrEP is taking the HIV medication called Truvada, if you are not infected with HIV to help prevent HIV infection)? ☐ YES ☐ NO
13. If yes to #12, how much do you know about PrEP?
☐ A Lot ☐ Some ☐ A Little ☐ Nothing
14. Do you know where to get PrEP in your community? ☐ YES ☐ NO
15. Would you consider using PrEP? ☐ YES ☐ NO ☐ NOT SURE
16. How would you feel about receiving HIV/STD information in church/place of worship?
☐ Yes, I would be okay with it
☐ No, I would not be okay with it
☐ I don't go to church/place of worship
Please Explain: _____

17. Are there barriers (things that get in the way) to receiving HIV prevention and/or treatment services in your community? ☐ YES ☐ NO
If yes, what are they? Check all that apply:
☐ No transportation
☐ No services exist in my neighborhood
☐ Don't know where to go
☐ It takes too much time
☐ No health insurance
☐ Providers will judge me
Other: _____
18. What do you think can be done to stop new HIV/STD infection?
Please Explain: _____
